Resident Physician

JOURNAL FOR THE HOSPITAL STAFF OFFICER

NOVEMBER 1961

Urgent Tasks Confronting Medicine

7 ways to a better internship

Medicine at the Bottom of the World!

November 1961, Vol. 7, No. 11

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Resident Physician

November 1961, Vol. 7, No. 11

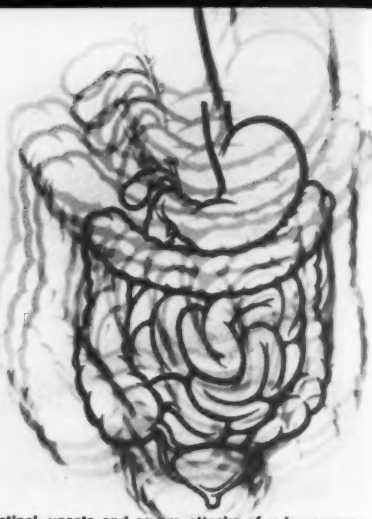
Articles

Resident Physician is published monthly on the fifteenth by The Resident, Inc., with publication offices at 34 North Crystal St., East Stroudsburg, Pennsylvania. Executive, advertising and editorial offices at 1447 Northern Blvd., Manhasset, New York.

"Murel"

Brand of Valethamate bromide

promptly controls pain and spasm



In the G.I. tract In acute gastrointestinal upsets and severe attacks of pylorospasm, pain and spasm are promptly controlled.[1,2] "Murel" with Phenobarbital has been employed in functional disorders of the gastrointestinal tract with outstanding success.[2]

In the G.U. tract "Murel" rapidly relieves smooth muscle spasm in renal colic, irritable bladder, pyelonephritis, pyelitis, and urethritis.[1-3]

In the Biliary tract In 22 patients with posthepatic biliary disease and chronic cholecystopathies with or without stones, "Murel" relieved pain in all but 2 patients, who required subsequent surgery.[4]

as adjunctive therapy in Peptic Ulcer Among 97 peptic ulcer patients, 92 per cent experienced complete or substantial relief of pain within three days.[5]

Remarkably free from drug-induced complications: Visual disturbances, mouth dryness, interference with micturition or bowel evacuation occur in only 4 per cent of cases, compared to as high as 15 per cent with other antispasmodics, especially the anticholinergics.[1]

Average Suggested Dosage: Oral—40 to 80 mg. daily (in divided doses), depending on condition and severity. The higher range of dosage is usually required in spasm of the genitourinary and biliary tracts. When anxiety and tension are present, "Murel" with Phenobarbital is suggested. **Parenteral**—In acute, severe spasm—1 to 2 cc. (10-20 mg.) I.V. or I.M. Subsequent injections may be given every 4-6 hours up to a maximum dosage of 60 mg. in 24 hour period.

Precautions: As with other antispasmodic agents, caution should be exercised in patients with prostatic hypertrophy, glaucoma, pyloric obstruction with significant gastric retention, and in the presence of cardiac arrhythmias. "Murel" Injectable and phenobarbital sodium in solution are chemically incompatible when mixed in the same syringe.

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Available:

No. 314—"Murel" Tablets—Each tablet contains 10 mg. Valethamate bromide
No. 318—"Murel" with Phenobarbital Tablets—Each tablet contains 10 mg. Valethamate bromide with ¼ gr. phenobarbital. **(Warning:** May be habit-forming.)
No. 315—"Murel"-S.A. Sustained Action Tablets—Each tablet contains 40 mg. Valethamate bromide
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Bottles of 100 and 1,000.

No. 405—"Murel" Injectable—Each cc. contains 10 mg. Valethamate bromide, in 5 cc. vials. (This sterile aqueous solution also contains 2% benzyl alcohol: adjusted to pH 5 with sodium acetate and acetic acid.)

References available on request.

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6130

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Resident Physician

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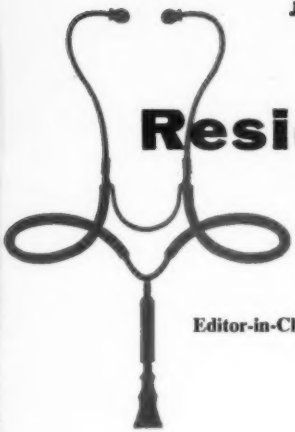
Journal for the Hospital Staff Officer

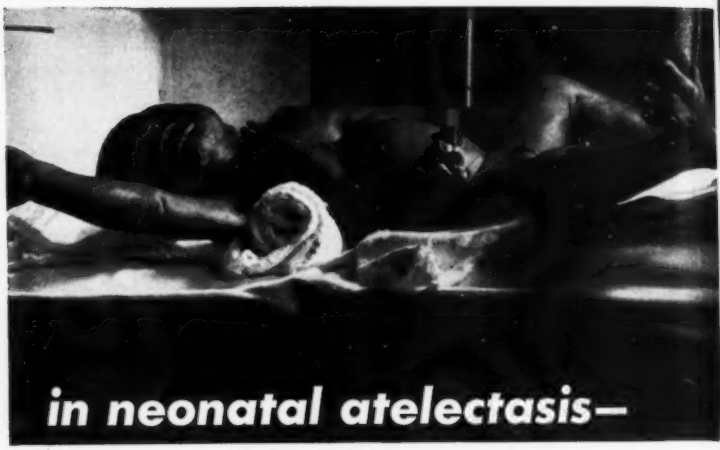


Resident Physician

November 1961, Vol. 7, No. 11

Articles are accepted for publication with the understanding that they are contributed solely to this publication, and will directly interest or be of practical value to resident physicians and interns. When possible, two copies of the manuscript should be submitted.

Subscription rate $10 per year. Single copies $1. Notify publisher promptly of change of address.



in neonatal atelectasis—

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(NONTOXIC MUCOLYTIC DETERGENT AEROSOL)

"... results are impressive. This dreaded condition usually improved in a few hours, and it was really striking to see a cyanotic baby with gasping respirations and suprasternal retraction become relaxed and pink in such a short period of time."[1]

In the elderly patient with chronic bronchitis "... favorable therapeutic response is obtainable with the use of Alevaire."[2]

ALEVAIRE
is very helpful in:

- neonatal asphyxia (due to inhalation of amniotic fluid, mucous obstruction, atelectasis)
- croup • laryngitis • tracheobronchitis
- pertussis • pneumonia • bronchial asthma
- emphysema • bronchiectasis • lung abscess
- pneumoconiosis • smoke, kerosene poisoning
- poliomyelitis (respiratory complications)
- routine oxygen therapy • tracheotomy
- prevention of postoperative pulmonary complications

Alevaire is supplied in bottles of 60 cc. for intermittent therapy and bottles of 500 cc. for continuous inhalation therapy. Alevaire should not be diluted. Alevaire solution is ready for use in a concentration optimal for fine droplet stability and therapeutic efficiency.

Write for illustrated brochure.

1. Smessaert, Andre, Collins, V. J., and Kracum, V. D.: *New York J. Med.* 55:1587, June 1, 1955.
2. Banyai, A. L.: *Geriatrics* 14:621, Oct., 1959.

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New York 18, N. Y.

Alevaire, trademark reg. U.S. Pat. Off.

Resident Physician

This COMPLETE formula protects your babies against butterfat intolerance

- assures optimal caloric efficiency
- maintains skin integrity
- eliminates sour odor

These advantages in Baker's Modified Milk result from complete butterfat replacement with controlled amounts of coconut and corn oils.

Since the infant's health depends upon total adequacy of his diet, Baker's Modified Milk also provides an optimum protein level (3.7 gms/kg of body weight/day), 7% carbohydrate as multiple sugars, and the Recommended Daily Allowances of vitamins and iron. That is why more and more physicians, and hospitals, specify Baker's Modified Milk. It is complete... at low cost per feeding. Made only from Grade A Milk—liquid or powder.

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REFERENCES: Jeans & Marriot: Infant Nutrition, Ed. 4, Mosby (1947) • Adam, Doris J.D., et al: J. Nutrition 66:555 (1958) • Hansen, A.E., et al: J. Nutrition 66:565 (1958) • Recommended Dietary Allowances, NAS-NRC Publ. 589 (1958) • U.S.-P.H.S. Milk Code, Federal Security Agency Publ. 220 (1953)

Baker's MODIFIED MILK

is scientifically formulated to duplicate the nutritional results of human milk

THE BAKER LABORATORIES, INC. • Cleveland 15, Ohio

Resident Physician

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Therapeutic Reference

The following index contains all the products advertised in this issue. Each product has been listed under the heading describing its major function. By referring to the pages listed, the reader can obtain more complete information. All products are registered trademarks, except those with an asterisk(*).

The captain prescribes a cure

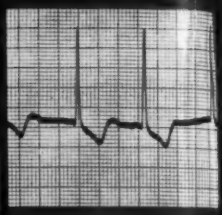
In the mercantile marine of the early nineteenth century, the captain—in addition to his strictly nautical duties—often had to fulfill the functions of physician and surgeon. Most often the problems were not difficult, for by this time effective methods of sanitation and ventilation had been devised, the seamen's faulty diet was improved, and the problem of keeping drinking water in usable condition had been solved by the substitution of iron tanks for wooden casks.

Boils were the commonest *surgical* condition, while constipation was the most prevalent *medical* complaint. The latter was kept in check by the enormous quantities of Epsom salts which formed the most important component of the stock of drugs. The ship's medicine chest usually included a booklet of instructions and sometimes, to simplify the difficult arts of diagnosis and treatment, different diseases were numbered to correspond with bottles containing suitable remedies. A favorite tale, perhaps apocryphal as are most salt-water yarns, is of an ingenious captain who, having decided that his patient presented symptom complex No. 9 and finding this bottle empty, rose to the situation by administering equal doses of No. 3 and No. 6.

—KARL VOGEL: *Great Adventures in Medicine*, New York, The Dial Press, 1952.

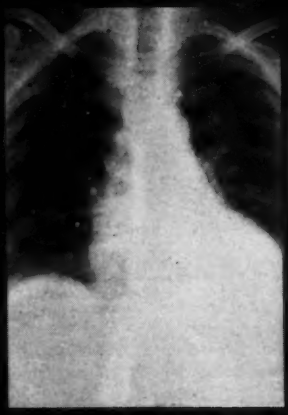
*before treatment**

Cardiac enlargement and pulmonary congestion

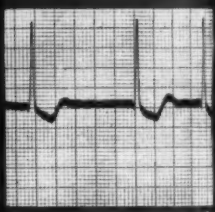


Left ventricular strain and hypertrophy (ST depression in Lead V5

after one month on HYDROPRES*



Reduction in heart size and clearing of congestion



Changes toward normal (less ST depression)

*case report

effective by itself in many hypertensives...
indicated in all degrees of hypertension

HYDROPRES

HYDRODIURIL® with RESERPINE
HYDROCHLOROTHIAZIDE

is pharmaceutical advertising really "advertising"?

of course it is, though some have called it "education" . . . not <u>really</u> "advertising."

Of course it's "advertising". . . a frankly competitive activity of the American private enterprise system to which this industry belongs. Of course it's "advertising"... created in the hope of getting the physician to note and read; of persuading him, by setting forth proven indications and advantages, to learn about a drug; and of thereby helping him alleviate suffering or cure disease by prescribing it.

"Advertising"? Surely! BUT indisputably different from any other advertising in the world (which is just what has led people to devise various different names for it). For in its proper role it communicates the vital information ... good, bad, and indifferent ... and it keeps the physician abreast of each useful new clinical application and each new danger revealed during increasing use of the drug.

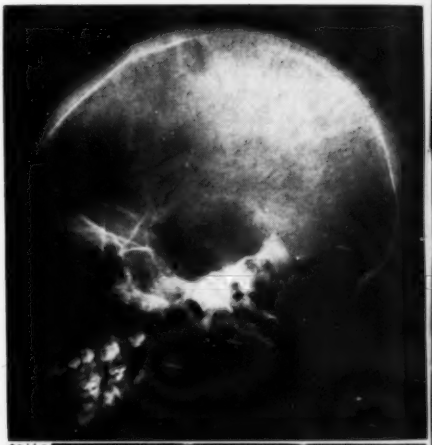
There's been a lot of talk about "over-advertising", and there may have been occasional excesses. But consider the potential dangers, in this era of astonishing new drugs, of "under-advertising"... in view of the complexity of modern drug therapy; the lag of 6 to more than 18 months before the appearance of definitive medical articles on new drugs; and the fact that there is no other source of such comprehensive information about a new agent as the company that ran it through the crucial gauntlet of animal pharmacology and clinical investigation.

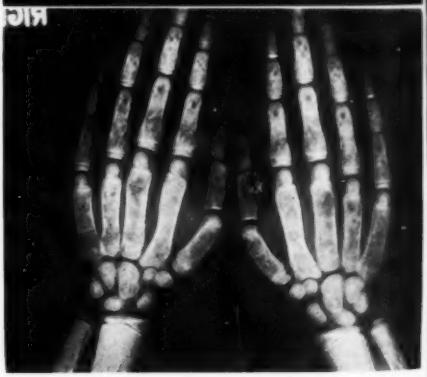
This message is brought to you on behalf of the producers of prescription drugs. For additional information, please write Pharmaceutical Manufacturers Association, 1411 K Street, N.W., Washington 5, D.C.

Viewbox Diagnosis

Edited by Maxwell H. Poppel, M.D., F.A.C.R.,
Professor of Radiology, New York University College of Medicine and Director of Radiology, Bellevue Hospital Center

A seven-year-old Negro female complaining of swelling of the abdomen, weakness and shortness of breath.





What Is Your Diagnosis?

1. Normal
2. Cooley's anemia
3. Osteogenesis imperfecta
4. Osteopoikilosis

(Answer on page 197)

PATIENTS WITH SEVERE URINARY PAIN WANT RELIEF NOW.

Rx PYRIDIUM®

brand of phenazopyridine HCl

Two Pyridium tablets t.i.d. relieve the pain of urinary infection in only 30 minutes. During the first 3 to 4 days of therapy, Pyridium, prescribed along with any antibacterial of your choice, will make your patient comfortable until the antibacterial reduces inflammation and controls the infection.

AVERAGE DOSE: Adults—2 tablets t.i.d. Children 9 to 12 —1 tablet t.i.d. SUPPLIED: 0.1 Gm. tablets, bottles of 50. PRECAUTIONS: Pyridium is contraindicated in patients with renal insufficiency and/or severe hepatitis. *Full dosage information, available on request, should be consulted before initiating therapy.*

WARNER CHILCOTT

MORRIS PLAINS, N.J.

6P12

Read the EKG . . .

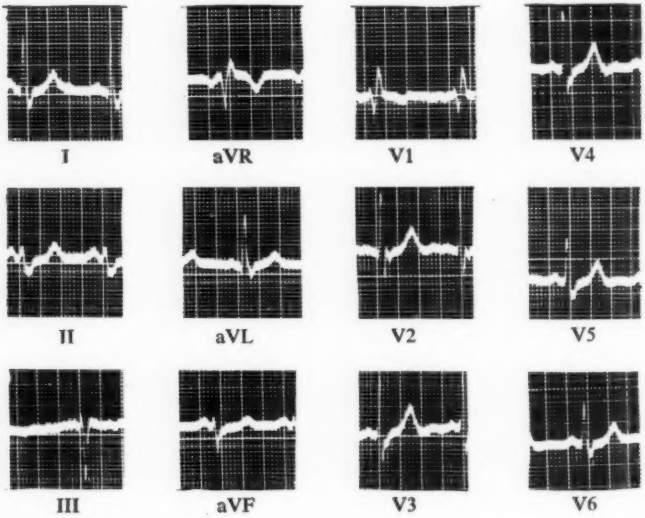
Edited by Albert L. Rubin, M.D.
Associate Professor of Medicine, Cornell University Medical School

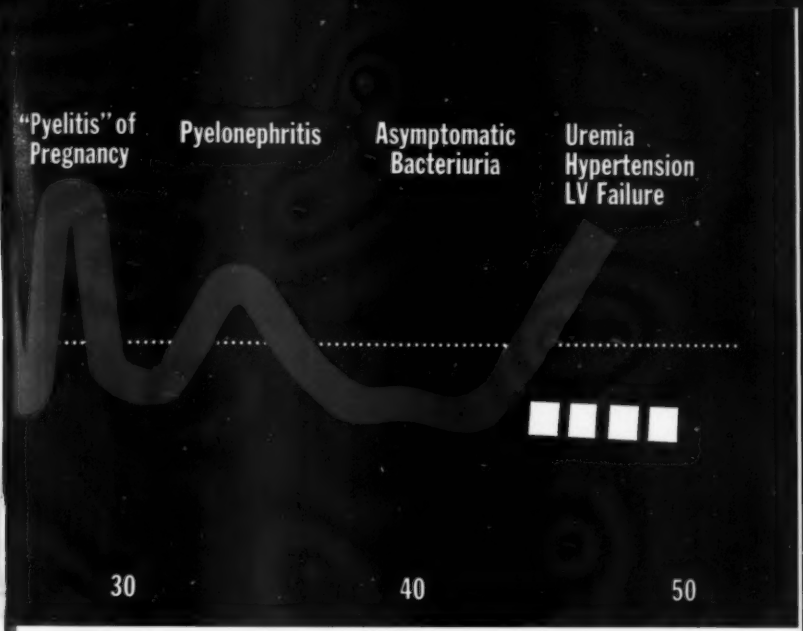
What Is Your Diagnosis?

CASE: A 46-year-old woman had a routine electrocardiogram taken prior to elective surgery.

EKG: Heart rate: 75
Left axis deviation
PR interval: .18 seconds
QRS interval: .16 seconds
QT interval: .42 seconds
RSR complex aVR, V
Prominent wide S wave I, II, aVL, V 4-6
Delayed intrinsicoid deflection

(Answer on page 197)





Furadantin®

BRAND OF NITROFURANTOIN

prompt ▪ thorough ▪ dependable ▪ safe ▪ economical control of infection throughout the urinary system

"... seems to be by far the most effective drug to be employed, and this has been substantiated in practice. It is a drug of low toxicity and, what is more important, bacteria rarely if ever become resistant to it. It can be employed for long periods of time, is bactericidal and does not favor the appearance of monilial infections."[2]

Average FURADANTIN Adult Dosage: 100 mg. tablet q.i.d. with meals and with food or milk on retiring. For acute, uncomplicated infections, 50 mg. may be administered. If improvement does not occur in 2 or 3 days, increase the dose to 100 mg. q.i.d. Supplied: Tablets, 50 mg. and 100 mg. Oral Suspension, 25 mg. per 5 cc. tsp.

References: 1. Birchall, R.: Am. Practit. *11*:918, 1960. 2. Sanjurjo, L. A.: Med. Clin. N. Amer. *43*:1601, 1959.

Complete information in package insert or on request to the Medical Director.

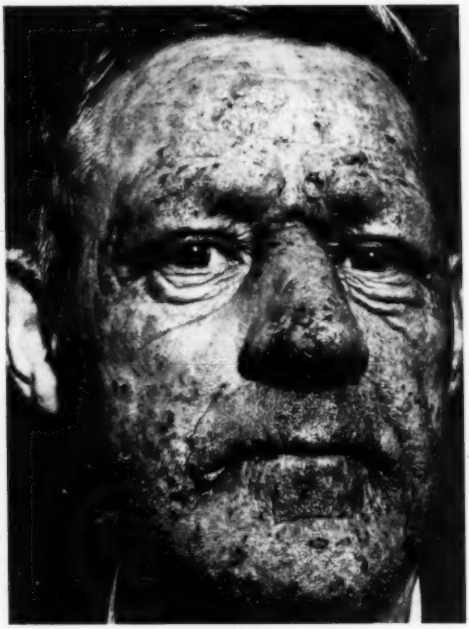
EATON LABORATORIES, Division of The Norwich Pharmacal Company, NORWICH, N. Y.

DERMATOLOGY

Diagnosis, Please!

Edited by Rudolf L. Baer, M.D., Professor and Chairman of the Department of Dermatology; Alfred Kopf, M.D., Associate Professor; and Morris Leider, M.D., Associate Professor, New York University School of Medicine.

DESCRIPTION: The eruption was 1) limited to the "exposed" areas, 2) flared up seasonally in August and September and 3) cleared after the end of the ragweed pollen season. Patch tests with ragweed oleoresin were strongly positive.



What Is Your Diagnosis?

1. Angioneurotic edema due to penicillin
2. Ragweed contact dermatitis
3. Dermatomyositis
4. Polymorphous light eruption

(Answer on page 197)

Witch Doctors guaranteed to cast a decorative spell over your office, or home

African Ebony Sculptures

These witch doctor figures are handcarved by members of the Wazaramu tribe in Tanganyika. The wood is solid ebony, as hard and shining as black marble.

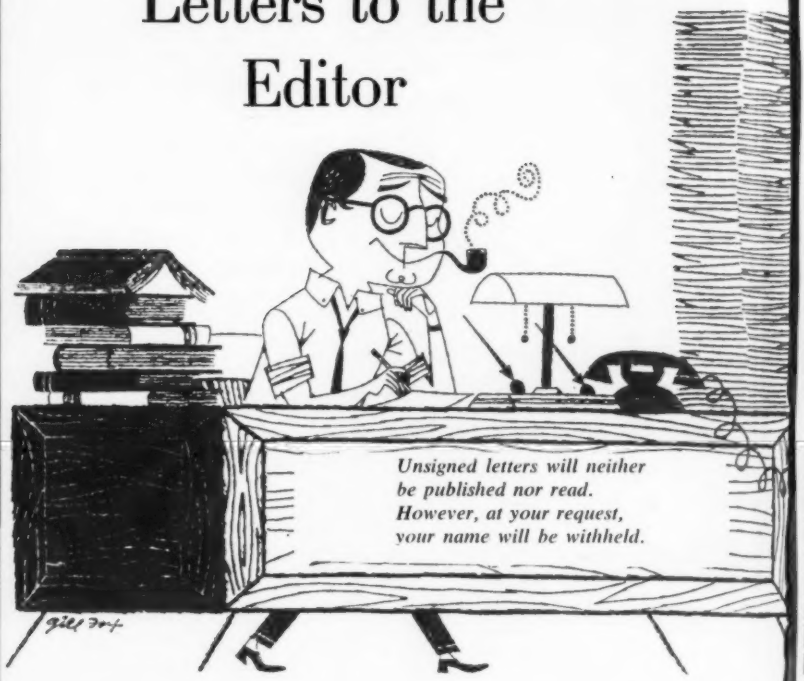
Because they are made by individual native craftsmen, no two figures are exactly alike. This means that at a small cost you can get a work of art—an original sculpture—that is unique. Sizes range from 12 to 15 inches in height.

Price: Figure A, $6.95 Figure B, $5.95.

To cover packing, mailing and insurance charges, please add (for each figure ordered) 45 cents for shipments East of the Mississippi, 95 cents for shipments West of the Mississippi.

MEDICAL TIMES OVERSEAS, RP 1447 NORTHERN BLVD., MANHASSET, N. Y.

Letters to the Editor



Miami Program

The proposal which was made for a postgraduate program for foreign physicians by Doctor Henry K. Silver, Professor of Pediatrics, University of Colorado, in the July 1961 issue of RESIDENT PHYSICIAN was of great interest to us at the University of Miami School of Medicine. Doctor Silver suggested that the most important features of a postgraduate program would be instruction in English, familiarization with American equipment and techniques, refresher courses in certain aspects of diagnosis and therapy, and the personal integration into the American way of life.

Doctor Silver went on to indicate that he thought this should be done at a variety of centers

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and that the amount of time spent should be proportional to the needs of each individual or groups of individuals. He foresaw one such center on the West Coast, one on the East Coast, and he suggests that a third center in New Orleans, Denver, or Los Angeles might be set up for graduates from Mexico, Central and South America.

I would like to draw the attention of your readership to the fact that the University of Miami School of Medicine has, for the past year, presented a postgraduate program such as he suggests to over 500 foreign born physicians. All of them have come from Mexico, Central and South America. The program has been structured in a fashion such that intensive courses in English are given, the American clinical approach is stressed on a personal basis, and every group of five or ten physicians has his own American tutor who helps him integrate into the American way of life. In addition, four days of testing are done at the beginning of each program and at the end of each program, and by this means the specific needs of each individual can be objectively measured and a separate tutorial program arranged to meet these needs. Furthermore, we are able to measure our success in meeting individual and group academic and linguistic needs.

Any of your readers interested in additional information concerning this program is invited to correspond with us.

Emil P. Taxay, M.D.
UNIVERSITY OF MIAMI
SCHOOL OF MEDICINE

South Africa Progress Note

During the period of my residency in Suffolk, Va., until March of this year, I became very interested in x-ray units and procedures, especially by the encouragement of our very able radiologist. Today, when I opened my copy of *South African Medical News,* an independent newspaper for the medical profession, published monthly in South Africa, I really felt stimulated, and also to some extent proud. Medical development in this country is undoubtedly making rapid progress, and I thought I would send you a clipping, which you might like to publish or extract, as it may possibly be of interest to doctors, and friends of mine in the U.S. This development was of particular interest to me because prior to my service in the U.S.A., I had served on the staff

—*Continued on page 48*

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of the National Hospital in Bloemfontein for almost three years as a resident in thoracic surgery. . . .

Johannes J. Frick, M.D.
PAARL HOSPITAL
SOUTH AFRICA

• *The clipping refers to the installation of "the most modern x-ray unit available in Southern Africa" in the Bloemfontein National Hospital. In addition to an image intensifier, the new unit is equipped with a 16 mm. cine camera.*

Overseas Study

I am going to complete my pediatric residency training on July 1, 1962. I am interested in overseas study after that date. I would appreciate it very much if you could provide me with any information you have regarding the opportunities available.

DALLAS, TEXAS K.C.H.

• *There are two main sources for the information requested. Since many physicians have written us expressing an interest in opportunities for study overseas, the following information is given in some detail:*

The United Nations Educational, Scientific and Cultural Organization (UNESCO) publishes an International handbook of fellowships, scholarships, and educational exchange. Volume twelve for 1960-1961 provides a comprehensive listing by specialty, nation and sponsor group of the opportunities available in 115 nations and territories. These scholarship and fellowship listings cover 100,000 individual opportunities offered by 1,761 agencies and describes study periods ranging from two weeks to eight years. The volume, entitled "Study Abroad," may be available at your local library or may be obtained by writing UNESCO, United Nations Headquarters, New York City, New York.

The second source of information is The Institute of International Education with headquarters at 1 East 67th Street, New York 21, New York. As a clearing house for information for foreign students the IIE can refer interested persons to some of the many organizations which offer information, advice, and in some cases practical help in meeting the special needs of U. S. citizens wishing to study abroad.

Publications of the IIE include "Open Doors," a report on five surveys including one on students from the U. S. A. in foreign institutions of higher education, and faculty members from the

—Continued on page 52

—*Continued from page 48*

U. S. A. studying abroad. Priced at $1. This is published in May.

"United States Government Grants." Graduate study under the Fulbright Act, Inter-American Culture, and the Smith-Mundt Act, published in May.

"Fellowships Offered by Foreign Governments, Universities, and Private Donors." Fellowships and scholarships administered by IIE for study abroad. Published annually, no charge.

"Summer Study Abroad." Programs at foreign universities for U. S. students. Published annually, no charge.

Love of Country?

HURRAH FOR CLYDE SECOY, M.D. I agree most heartily with his pertinent sentiments (RESIDENT PHYSICIAN, September, "Letters to the Editor") with reference to a physician's duty to his country and his disdain for doctors who overtly and covertly attempt mitigation of so honorable and solemn an obligation.

There are men who now believe the sentiment of patriotism is chauvinism and the nation's fighting soldiers alive and dead are not to be served, nor are the nation's traditions to be respected and defended.

This group did not register with the Berry Plan. Safe enough during the indolent days of the

—*Concluded on page 58*

—*Concluded from page 52*

cold war and dwindling draft calls . . . but now that megaton dust chokes dreams of tomorrow and the Berlin Crisis backs us to the wall, sounding once again the bugle call to arms, now where are our residents in *defection* and *dodging?* They are sudden volunteers in the NIH and Public Health Service, seeking professional and career shelters. Because of the slack created by their conscientious *dodging,* both active and inactive reserve physicians are being called for the 2nd time to duty, interrupting residency training and family life.

Are they physicians who ask not how they may serve their country, but how their country may serve them? Do they deserve the robes, if they hold not dear that indivisible trinity, love of fellow men, love of God, and love of country?

Oh, that patriotism were once again a noble sentiment among all men and among all physicians; for if they love not first their own nation, how can they know the love of all men and all nations?

CAPT. ANTHONY G. GRISTINA, (MC) USAFR
HOSPITAL FOR SPECIAL SURGERY
NEW YORK, NEW YORK

Perrin H. Long, M.D.

Editor's Page

ON THE HISTORY AND PHYSICAL EXAMINATION OF THE PATIENT

II. The Physical Examination

It would seem quite logical to believe that probably the greatest cause of missed diagnoses is an imperfect physical examination. At least that is what one hears when discussing this subject with one's colleagues. Not that we mean that a careful and meticulous physical examination of a patient can make up for a badly taken and slovenly history. Rather, that the doctor who takes a good history and performs a thorough physical examination *will be able to make the major diagnoses in about eighty to eighty-five percent of the patients that he sees.* Now, certain of our readers will consider this last statement an exaggeration but if they sit back and consider this matter, the verity of it will dawn upon them. Furthermore, if one has (and one should have) confidence in his ability to take a good history, do a good physical examination and then from the data derived from these two sources synthesize his diagnosis and formulate his prognosis, he can in many instances dispense with further tests except an examination of the urine and of the blood.

In this day and age when your livelihood and mine are

being threatened by the high cost of medical care, anything that we can do to lower costs is very much worth while. "Tests" and "studies" are very expensive ways of making up for ineptness in history-taking and the physical examination of patients, and for the timidity, or even real fear which assails the doctor who is inept. Literally, millions and millions of patients' dollars are wasted each year because their doctors do not feel they can trust their own ability to use properly the simplest tools at their disposal, namely the history and physical examination.

Furthermore, in discussing the decline of excellency in history-taking and physical examination with his peers, your Editor has learned that the presentation of poor histories and poorly done physical examinations by candidates for the Board of Internal Medicine is the most frequent cause of failure in the oral examinations of this Board. He has been told that candidates frequently have only the vaguest understanding of the physiological or pathological factors concerned with certain physical signs. Recently, one of his colleagues who was examining in the "orals" of the Board of Internal Medicine asked each candidate, when they spoke about the heart sounds, "How is the first sound in the tricuspid area produced?" All candidates asked that question became flustered, then panicked, and it took the examiner some time to get them back in the groove. These same candidates could discuss transaminase backwards and forward. This is a serious indication of the low state of the average candidate's knowledge of physical diagnosis. Another illustration of this. Your Editor found real apprehension on the part of certain of his residents, when he insisted that patients recovering from lobar pneumonia be sent home *when their lungs were clear on percussion, palpation, and auscultation!* The residents wanted "to take a chest plate." No wonder the costs of medical care are going up!

Now what is a good physical examination? Well, let us say that it should begin on the top of the head and on the way down to the bottom of the soles of the feet, everything visible to the unaided or aided eye should be looked at, everything that can be felt should be felt, every orifice should be entered and looked into, everything that can move should be moved, everything that can be percussed should be percussed, and everything that can be listened to should be ausculted. To get the best understanding from such a systematic examination, the doctor *must know* the physical (physics) background of both normal and abnormal signs. With a thorough knowledge of the physical meaning of what he hears, sees, smells, feels, and at times even tastes, he is well prepared for the proper practice of his profession.

Now from the teaching point of view, what does the neophyte need in the way of instruction? First of all, if not already curious, an attempt must be made to instill curiosity in him. He must be continuously observant of his environment. *He must see what goes on and by.* People, dogs, birds, everything living, everything nonliving, and be able to describe them. We have often wondered what the results would be, in terms of careers in medicine, in a medical class made up entirely of Eagle Scouts.

Next, proper techniques of palpation, percussion and auscultation must be learned. Now here is the area in which practice makes for perfection. One can percuss anything, one can palpate anything (Dr. Joseph Colt Bloodgood, the famous Hopkins teacher in the cancer field, used to always say to his classes. "Never miss an opportunity to palpate a woman's breasts,") and one can always auscult his own chest or abdomen. Practice, practice, practice until these techniques become second nature to you. In this area, there is some divergence of

opinion as to whether the student should be led immediately to the patient, or should develop his initial skills on normal people, i.e., his partner in class, his wife, or his children. We favor a thorough experience on normal individuals before the neophyte is exposed to abnormal physical signs. However, while the ability to describe accurately what you see, feel, smell or taste is something to be sought after assiduously by the medical student, intern, and resident; little will you gain unless the mean-

The Berry Plan and the Doctors Draft

RESIDENT PHYSICIAN *has learned that between four hundred and five hundred doctors will be drafted by the end of December. This is in addition to the one hundred and fifty called in July. Depending upon the world situation, there may or may not be a draft of about one hundred to one hundred and fifty doctors next spring. Of course, all the figures would be revised upwards if Congress authorized and the President utilized a further increase in the manpower of the Armed Forces.*

As far as the thinking goes today in the manpower policy area of our Armed Forces, there is no intention of keeping doctors currently on active duty for two years in uniform for an extra year, during the period of tension which our country is facing. It is believed that between volunteers in the Berry Plan and relatively small intakes under the Doctor's Draft Act, the needs for doctors by the Armed Forces can be easily met. However, if the present situation deteriorates and Congress increases the Armed Forces, other steps may have to be taken to provide an adequate number of doctors to take care of the members of the commissioned services and their depend-

ings and significance of what you are describing are perfectly clear to you. Therefore it is absolutely necessary that practice be accompanied by studies designed to bring clarity to your mind about "meanings and significance." With practice-produced perfection of technique and study-induced clarity of mind in regard to "meanings and significance," then under all conditions you will enjoy that feeling of confidence which marks the good doctor, when he faces his patient.

ents under the Medicare who are eligible for Medicare.

It is comforting to know that as far as current thinking goes, there has been absolutely no thought put forward relative to tampering with the present structure or working of the Berry Plan. It would appear that unless the world goes to pot, Berry Plan residents can count on finishing their training before being requested to perform military duties. This was the spirit in which the Plan was conceived, and it is splendid to see that the idea of providing an adequate number of specially trained physicians and surgeons for the military from the Berry Plan and the military residency programs is not being altered in the present crisis. This should be comforting to the young men who are in these programs.

There is another facet of the mobilization of doctors which should be understood by all, and that has to do with some medical students and a few interns and residents who are in the Ready Reserve and are enrolled in Ready Reserve units. The Reserve Law reads:

"(b) To achieve fair treatment as between members in the Ready Reserve who are being considered for recall to duty without their consent, consideration shall be given to:

(1) the length and nature of previous service, to assure such sharing of exposure to hazards as the national security and military requirements will reasonably allow;

(2) family responsibilities; and

(3) employment necessary to maintain the national health, safety, or interest."

Those medical students, interns and residents in the Ready Reserve, who belong to Ready Reserve Units, alerted, or called to active duty, have the right of appeal under the part of the Reserve Law just quoted above. What the official attitude towards appeals will be, we do not know at this time. However, from all points of view, RESIDENT PHYSICIAN would consider it very callous and stupid, if military authorities ordered medical students to active duty before they had completed their medical course and one internship year, or ordered interns to active duty before they had finished their intern year.

However, we must remember that if the world situation deteriorates and increased demands for military manpower have to be met, then the Berry Plan and the military residency programs may have to be altered.

Perrin H. Long.

PUBLISHER'S NOTE

As Resident Physician went to press, our information as to the expected doctor draft was confirmed. The Defense Department has called upon Selective Service to draft 495 physicians. The Defense Department said that this special call was "necessary to meet the requirements of the current military build-up requested by the President and authorized by Congress." The draft will seek 275 physicians for the Army, 70 for the Navy and 150 for the Air Force.

THE SIGERIST LECTURE *Yale Medical School, Auspices of "Yale Medical Democrats."*

Yale Medical Democrats and other friends—

To give your first Sigerist Lecture is a distinguished honor. Because you have chosen that great medical historian as your patron saint, certain obligations devolve upon your lecturers. The use of his name reminds us that to look into the future with wisdom, we must develop some insight into the past. We cannot intelligently, or safely, speculate about what lies ahead, unless we have some feeling for what has gone before, but nonetheless, God forbid that we should be bound by the past.

Henry Sigerist, who incidentally made an important speech here at Yale[1] just 25 years ago this month, has traced for us in his many writings, man's painful efforts to save his own life and preserve his health, from earliest times, by measures which for convenience we may call medical. Always he studied the history of medicine in its proper relation to that of the culture in its broad outlines. He looked into the future of medicine constructively, seeking ways in which it might better serve mankind in a world in process of cataclysmic change. To yearn for the good old days, said he, is pure romanticism. Physicians must be akin to the social problems of their time and seek ever to understand them. Ideals rather than ethics per se are the important consideration.

James H. Means, M.D.

URGENT TASKS Confronting Medicine

The overwhelming fact in our day is the crescendo rise in population. From it stems, directly or indirectly, most of our vital problems. This growth in population, strangely enough, is occurring in famine areas no less than in affluent America. Have we the wisdom and strength to meet these threatening conditions with foresight and resolution, or shall we stumble along with attention only for immediate problems?

A couple of months ago, I attended a panel discussion on "Medicine of the Future" in which five distinguished men participated. To my amazement, these panelists said nothing about

problems of population, until forced to do so by questions from the floor. I am sure that reluctance to face such questions is not due to escapism but rather to genuine bewilderment as to what can be done about them. In any comprehensive consideration of the "Medicine of the Future," however, the population explosion has got to be accepted as an inescapable part of the overall problem. The magnitude of what man is up against is most easily grasped by a glance at the curve of his increase (graph).

Critical stage

It is evident that we are entering a very critical stage. Our increase is changing from a slow gentle rise to a skyrocketing type of course. We are changing direction through an arc of nearly 90°. On a planet of fixed size, it is obvious such a course cannot be followed indefinitely. For survival of the human race, the direction of the population curve will have to be radically altered, and the sooner this is done, the better man's prospects on earth. Man could conceivably do this for himself, but if he doesn't, nature will do it for him, in some fashion frightful to contemplate.

The only ways in which population growth can be checked, or halted, either by man, or by nature, are by slowing birth rate or accelerating death rate. Man is in possession of methods by which he can control his birth rate, but has he the will and skill to use them effectively? His death rate he can only increase by methods, which to civilized man at least, are unacceptable, or at best, repugnant. These include suicide, homicide, genocide, and war which now can be nuclear. There are also negative possibilities, such as withholding food from famine areas, or abolishing all kinds of medical services. These too are unacceptable. Therefore, if man wants to reduce his increase in numbers, his only recourse is to birth control.

Malthus

If he fails to make sufficient use of this, Nature will take over, and ultimately *homo sapiens* will go, as have thousands of other species before him, into extinction. There are several ways in which this might happen. Outrunning the food supply and starving is the most obvious. This is what Malthus[2] predicted a century and a

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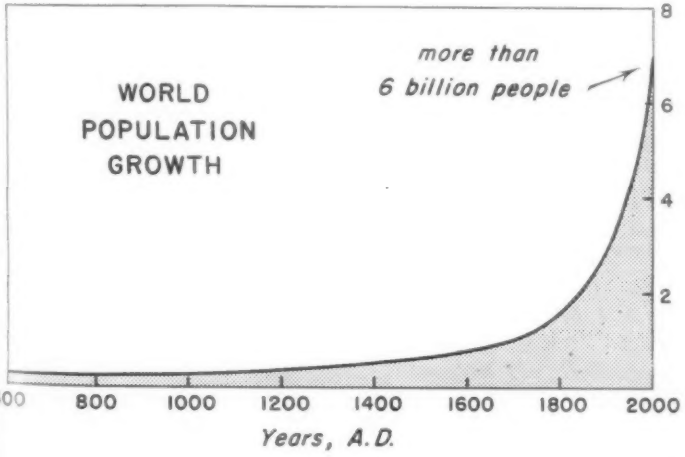
half ago. The first world-wide famine might not prove fatal. After a billion or so people had starved to death, the food supply might again come into balance with the population, and a respite, for a time, might be had. But unless the birth rate were, thereupon, held in check, the cycle would in time be repeated, perhaps, over and over again until the species finally died. The process could be accelerated by widespread and uncontrolled disease. On the other hand, it might be delayed repeatedly by the achievements of science in increasing food supply, very likely by synthetic processes of one sort or another, which utilized nuclear or extra-terrestrial sources of energy.

A less well known threat to man's survival, receiving attention from ecologists, but not much from anyone else is, instead of lack of food, lack of space. *Lebensraum,* the Germans call it.

Carrying capacity

There isn't much precise information about this in human beings, but there is some remarkable evidence in other species. It has been found, for example, in a considerable number of mammals, that populations undergo rather regular cyclic fluctuations. The population rises until a peak is reached at which time a lot of



individuals die rather suddenly, and for no very obvious reasons. The ecologists call this phenomenon the *"die-off."* Of it, J. J. Christian[3] says—The cycle length will be related directly to the time it takes the population excess over death rate to peak to a point beyond the *carrying capacity* of the environment, hence highly *stressed* conditions.

One thinks, in this connection, of the famous lemmings, and the snowshoe hares, of which your Professor of Biology, E. S. Deevey[4] has written with such wit and discernment. Then there is a very specific observation on a die-off episode in a herd of Sika deer, reported by Christian, Flyger, and Davis.[5] An island in Chesapeake Bay of 280 acres was inoculated, in 1916, with "four or five" members of an alien species of deer. In this salubrious spot, they were fruitful and multiplied reaching, by 1955, a population of 280-300, or a density of one deer per acre. Then in the winter of 1958, in two months' time, sixty percent of the herd died. Studies of the dead deer showed no evidence of malnutrition, nor convincing evidence that infection played a role in the die-off. Two years later, the remnant of the herd made an apparent recovery, and growth of population was resumed, as before. What was regarded as the most significant anatomical finding was a gain in weight of the adrenal cortex (1955-1958), and a return to usual weight in 1960, when the recovery period had set in.

Environment

Christian, in casting about for an explanation of the die-off, seized upon the so-called alarm reaction of Selye[6] and hypothesized that the deer might have died of exhaustion of the "adrenopituitary system," caused by stress which in turn resulted from exceeding the *"carrying capacity of the environment."* That is to say, death from stress due to overcrowding.

Whether anything of this sort has ever happened to human communities, I am sure I do not know. The appearance of the world population curve, however, suggests that if it never has happened it could do so in the not too distant future. That man itself could have a die-off from stress, even with no significant food shortage, when his numbers exceed, spacewise, the carrying capacity of his environment, is at least a possibility worth considering.

Learn from the life of a lemming. Be warned by the fate of a deer!

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Dr. and Mrs. Henry E. Sigerist taken in Switzerland shortly before his death.

The reason for touching on these matters, ever so lightly, is because they will, inevitably, color your thinking and affect your activities, not only as men and women of medicine, but as members of the human race, in the kind of world that lies ahead. They need mention also to point up the frightening apathy that most people have concerning population problems at the present time.

I am convinced that wherever you go, or are going, in medicine, the pressure of the growing population, constantly will bear down on you. It will modify your goals and your opportunities, as well as your modus operandi. It will progressively interfere with your freedom. It is one of the doctor's duties to understand the behavior of people. He must know that as their number increases and their living space decreases, and as they despoil the planet of its natural resources, their capacity to remain civilized may be expected to diminish.

But let not all these considerations depress you, rather let them challenge you to overcome new obstacles and find satisfaction in such accomplishment. Whether you serve your medical calling by bringing medical care to individuals, to communities, or in some component of what we may call global medicine, you will al-

ways be confronted with the proliferation of human beings and with all that follows in its wake. The practitioner of medicine must develop some understanding of what ever more crowding does to people in general and especially to his patients. The public health people must know that the elimination of one disease may create several new ones. There is no more sardonic fact than that by saving lives we may lose them. Improved sanitation without corresponding increase in food supply may do no more than to exchange disease for famine. He who meddles with an ecosystem (a balance of nature or culture) without appreciating the possible consequences, does so at the peril of many people.

Ill effects

There can be no doubt that crowding has a variety of ill effects on human beings, as well as on other species. It shortens their tempers, and heightens the stress under which they labor. Tension and hurry erode the leisure necessary to civilized living. This is particularly true of doctors! Standards of family living decline, largely because of lack of space. Anxieties build up over how financial, educational, social, and medical necessities are to be procured. More and more resort is made to tranquilizing drugs and the like. The struggle for existence is intensified. The precept, "love thy neighbor," is overshadowed by "survival of the fittest." But a conflict between God and Nature raises theological questions too awesome for the likes of us even to contemplate.

Decay symptoms

Prodromal symptoms of the decay of our culture are already apparent. Think what the modern motorcar is doing to our behavior. Behind a wheel an otherwise gentle person can become a public menace. Think of the depredations of Madison Avenue, of the widespread unwillingness to accept responsibility, of the prevalence of the passing of bucks, of the decline in civic pride in our congested cities, of increasing juvenile delinquency, of the dreadful state of transportation, of the deterioration of our manners and courtesies, etc., etc. All these may be attributed, primarily, to too many people.

I recall a conversation pertinent to all this held back in the interbellum era, with the distinguished discoverer of Vitamin C, Szent-Gyorgi. Several of us were asking him about the state of

science in the Europe of that time. "The trouble," he said, (I am quoting him from memory) "is that in Europe we live too close together, and we do not know how to live close together. We need civilizing influences."

Enough doctors

In the midst of such things, how is the physician to comport himself? First, he must everlastingly remember that medicine is for people, not for doctors. It is a professional calling not a business. It has high ethical and moral standards which it is your duty always to maintain in the full spirit thereof, and not merely in the letter. In these days of decreasing morality in business and politics, you can have the satisfaction of holding the line for decency in medicine. That is one of your urgent problems. Medicine, like matrimony, is not to be entered into unadvisedly or lightly; but discreetly, advisedly, and soberly and, under no circumstances, for the sole sake of financial reward. If you want to get an inkling how medicine can be enjoyed to the utmost, read Wilder Penfield's recent novel about Hippocrates, "The Torch."[7] You will find it a civilizing influence.

But we must focus also on immediate tasks. The most critical problem facing the medical profession today, and the public, lies in the field of medical education. How are we going to produce enough doctors to meet the needs of our rising population? At present, the population is running away from its supply of doctors. At the same time, medicine seems to be diminishing in popularity as a calling. We have been slow in recognizing these facts, but in September 1959, a very important government document, the so-called Bane Report,[8] was published, full of information on these matters. The Bane Report is actually entitled, "Physicians for a Growing America," and it was prepared by a "Consultant Group on Medical Education" at the request of the Surgeon General of the U. S. Public Health Service, Dr. Leroy E. Burney. Your own Dean Lippard was a member of it. The Group addressed itself to the question "How shall the Nation be supplied with adequate numbers of well-qualified physicians?"

From this Report we learn, among other things, that the growing need for physicians stems not only from the rapid growth of population, but also from an increased demand for personal medical services, and for specialized and non-clinical services.

"For the layman," says the Report, "the problem is evident. What do the people, the consumers of medicine, want now? They want more of the doctor's time! It is their one important complaint: Doctors are too busy . . . we'd like to talk more, to tell more; we'd like them to explain more; to listen more." Surely this is an impressive arraignment. It also puts us in a terrific quandary. With a supply of doctors which, relative to population, is diminishing, how can we arrange to have each one spend more time with patients? There would seem to be only two ways to do this, both of which will have to be used. First, to produce doctors at a faster rate, and then to allocate their work so that there is a minimal waste of their time. Time spent with patients, so long as information is being exchanged, is not to be put in the waste category.

The Bane Report shows further that, in 1930, we were graduating about 5,000 MDs per annum. This gave us about 125 per 100,000 people. In 1959, graduations had got up to about 7,000 per annum, which yielded approximately 132 MDs per 100,000 people. Merely to maintain the 1959 ratio, it is estimated, will require that we graduate 11,000 MDs in 1975. But actually, it is pointed out we shall, because of the increased demand for medical services, need considerably more than that.

To achieve such a goal will necessitate the establishment of an impressive number of new medical schools, and the recruitment of a host of new medical and premedical teachers. Teachers are vitally important in medicine, just as they are in all categories of education. In fact, without teachers there will be no education except self education. Noble as this last may be, it cannot alone serve all the purposes of medical education.

Students

As though all this was not enough, we have, coincidentally, increasing difficulties in the recruitment of medical students, both in numbers and quality. From another source[9] I've culled this—"A decade ago 40 percent of applicants for medical schools were straight-A students (in college); this figure has now dropped to 16 percent. A decade ago 3.5 students applied for each student accepted by a medical school; this ratio has now been cut in half." I can remember hearing President Conant of Harvard say, in the late thirties, I believe, to

the Faculty of Medicine, that the best brains were no longer going into medicine. Some do even now, of course, but not in so high a concentration. Mr. Conant's remarks incensed the Faculty somewhat, but subsequent events proved him right.

There has been a good bit of searching for the causes of the diminishing popularity of medicine as a calling. The Bane Report states the belief that medicine still "has enormous prestige and drawing power" and that deterrants to medical education are chiefly the excessive time required to complete it, and its high cost to the student. Both of these considerations put medicine into a poor competitive position with other types of professional education. The great array of opportunities in the Ph.D. categories is particularly undermining to medicine. Personally, I believe that medicine perhaps has *not* now got quite the prestige and drawing power that it used to have. As to "prestige," the political skulduggery of organized medicine has disgusted many people. And with regard to "drawing power," the opportunities in biology, biochemistry, and physics may draw, more strongly than medicine, those young people with a deep-interest in science.

A yet more recent report is the so-called "White Paper of the Association of American Medical Colleges,[10] put forth only last January. The preamble of this report begins with the statement that "the American people are deeply concerned about health," that is to say about obtaining health services and medical services, adequate to their needs. The growing shortage in all medical personnel is an obstacle to their obtaining them.

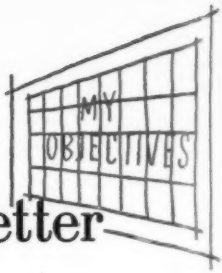
Both the Bane Report and the White Paper recognize that greatly increased support for medical education, including financial support directly to students, is imperative, and that it must come from a variety of sources, voluntary and tax supported, including massive support from the Federal Government.

Shorter course

Some attention, but by no means enough, has been given to shortening the overall course of the education of the physician. I have been convinced for years that this could be done without lowering standards, and have agitated for it from time to time, but with no noteworthy success.

I believe, however, that, if candidates for medicine could be

—Continued on page 160



7 Ways to a Better INTERNSHIP

William S. Stoney, M.D.

The present medical educational system prepares the student to recognize and manage a large variety of medical, surgical, pediatric and obstetrical conditions. Usually, however, there is no word of advice for the senior student as to his conduct during the internship year. Common sense, honesty, and dedication will guide the tyro during these early months as a physician. A few specific rules and general principles are offered here with the hope of making the first few months easier and the total experience more valuable.

Although the internship year is the most important and critical period of your training, a large part of this time you'll be harassed by overwork and fatigue. Rarely will you be thanked or praised for a good job.

Under these handicaps, and almost without your being aware of it, you'll find yourself slipping into short-cuts and sloppy work. Remember that it is on this foundation that your future will be built. Habits and skills learned at this time must be of the highest standards. You may plan to continue your training with one or more years of residency; therefore, the hospital staff will have an eye on your work and your conduct. An appointment as an assistant resident is usually based

on the first few months of internship. A poor showing on your part at first may end all chances for advanced training. On the other hand, a favorable impression made at this time may open the door for advanced training and experience. The attending physicians are also looking you over. Frequently the intern plans to practice in the same hospital and community. Friends and impressions made at this time may lead to future referrals and possibly partnership. So from a personal, medical and an economic standpoint, it pays to do a good job . . . the very *best* job you can.

1 THE INTERN has the longest working day in the entire hospital and probably in the community. An early start is necessary each day. He should be the first to see each patient each morning. The best intern I have known made it a practice to make rounds, change dressings, write all orders, and write a progress note on each patient each morning before the assistant resident arrived. This is a formidable goal but that particular intern is now chief of his service at a university hospital.

2 PUNCTUALITY is another absolute must for the intern. Almost every hospital procedure is carried out on some sort of schedule and usually requires more than one person. To be late is to waste the time of others and often results in serious disruptions in the schedule.

3 DAILY ROUNDS and conferences deserve the particular attention of the intern. This is usually the only formal teaching offered the house officer. Rounds are frequently held at the end of the day when the intern is tired and usually has new patients to see before he can go home or to bed. The temptation to skip rounds will be frequent.

A year ago at a large university hospital, house staff rounds were held each day just after the evening meal. Two of the interns felt that this was an unjust time as it delayed their getting home on nights off. Both interns stopped attending rounds and neither intern was invited to stay on as an assistant resident the next year. More seriously, at the end of the year one of the two was heard complaining that he did not feel adequately prepared for increased responsibilities. Attendance at teaching rounds each evening for a year would have bolstered his confidence.

4 A LARGE PART of daily hospital work is carried out by one group issuing orders for another group to execute. The intern, for example, writes orders for medications, fluids, etc. to be carried out by the nurse. In turn, he receives orders from the resident or attending physician. His conduct determines whether or not he is considered a "good" intern.

Two general principles apply here: First, the intern who can anticipate the next step and who can *go ahead without being told* makes a particularly valuable member of the house staff team. Secondly, the intern should remember that he is the executor of the orders of the resident or attending physician.

An attitude of cooperation and willingness to follow instructions gives the patient, the attending physician, and the intern a sense of confidence that all is well. An obstructive member of the team with constant counter-suggestions

"Was I going on or off duty?"

can disrupt this unity and discord will be reflected in the attitude of the patient.

5 THE INTERN has just completed an intensive comprehensive study of medicine. Frequently he may have up-to-the-minute information which will be valuable to the resident or attending staff. The best time for these suggestions is during the diagnostic study or pre-operative workup. Suggestions are usually invited at this time and if tactfully offered will be valuable to everyone concerned.

Every intern will learn that particular satisfaction of making a really brilliant diagnosis where others have failed; however, beware of concentrating on the bizarre and unusual in an attempt to appear "sharp." Remember that the attending physician and resident have one big advantage over you—*experience*.

6 THE MOST FREQUENT complaint directed toward interns and residents by hospital staff members is careless conduct in the presence of private patients. This is not usually careless professional conduct but rather careless conversation. It is always necessary to be very cautious in what we say to another doctor's patient. A few unguarded words can cause misunderstanding and loss of confidence between the patient and his doctor. The patient will ask your opinion about his operation or medication; this is very flattering, but if your answer should conflict with what the patient has already been told, the situation can become very embarrassing.

A seed of doubt or misunderstanding can lead to resentment and even malpractice proceedings. The warning flag should always go up when the patient begins to quiz you, and from this point the intern should be cautious and tactful. It is always better to say too little than to regret saying too much.

7 THE INTERN will have very little time of his own. An investment of a little of this time in a clinical or experimental study during the internship is a real mark of accomplishment. It can be compared to making a varsity letter and Phi Beta Kappa at the same time.

TO SUMMARIZE, the intern must constantly anticipate. His attitude should be one of willingness and cooperation. This is the time to set an example for yourself, one that you can look back on with pride and inspiration.

Clifford H. Keene, M.D.

Guest Editorial

Why a Prepaid Health Program Trains Doctors

The Kaiser Foundation, through its association with the Kaiser Foundation Health Plan and the Kaiser Foundation Hospitals, sponsors a broad program of medical and paramedical education. We provide training for medical interns and residents in a number of our hospitals. We support a school of nursing which has full national and staff accreditation. Seven of our hospitals collaborate with junior colleges and universities in training nurses, nurses aids and laboratory technicians. All of these activities cost money, take up the time of our busy staff, and add to the complexity of hospital routines. Yet our primary and ultimate responsibility is to the subscribers to the Kaiser Foundation Health Plan. Why, then, do we carry these extra responsibilities?

We do it because it is the best insurance we know for a high quality of care for our patients. We do it to make sure that they will receive the benefit of the newest advances in medical science.

It is a truism that the educator learns more through the educative process than his pupil can absorb. The physician or surgeon who teaches interns and residents must keep

alert to the latest developments in his field. If he fails to do so, the house officer delights in calling his attention to things he does not know. The doctor who makes rounds with the house staff every morning, or who lectures at grand rounds, must continually renew his knowledge of the basic mechanisms in disease. The staff doctor participating in these activities must organize his knowledge in order to communicate it effectively in the rapid exchange of the professional conference. Finally, doctors who must face unsolved theoretical and practical problems are most likely to undertake clinical, epidemiologic, or basic research. We believe that our staff education and house staff training programs account for the fact that so many of our doctors spend their off-duty hours in university clinics and research laboratories.

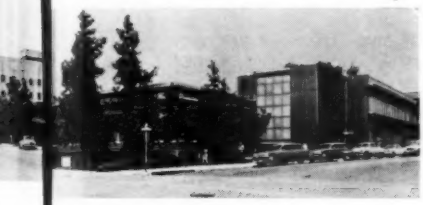
Many of our house officers and paramedical students will go out from our institutions to work in other hospitals. They will represent us in an unofficial but impressive way. Awareness of this is an unceasing spur to high quality by our attending staff. Without such stimuli as these, even the most interested and conscientious doctor can succumb to routine in treatment of patients. With these challenges, the physicians of the Kaiser Foundation Hospitals bring to their patients a way of practicing medicine that is attuned to the foremost achievements of our profession.

These are the simple and effective reasons why we in the Kaiser Foundation Hospitals invest our money, our time, our effort, and our faith in the training of doctors and those who will be their assistants in the work that lies ahead.

SAN FRANCISC BAY

Kaiser Foundation Hospitals

Combining the clinical environment of a university medical center with that of a modern private general hospital, the San Francisco and Oakland facilities, two of the Kaiser Foundation's 12 hospitals, offer graduate training to 20 interns and 66 residents.



Oakland

The Kaiser Foundation Hospital in Oakland was the first of a rapidly growing system of facilities to be established by subscribers to the Kaiser Foundation Health Plan. Opened in 1942, the Oakland unit is a modern, well equipped institution situated near the majority of the private hospitals on the east shore of San Francisco Bay. Within ten minutes' drive is the

San Francisco

The Kaiser Foundation Hospital in San Francisco opened in 1954 and was fully accredited for intern training in 1955. An active program for interns and residents has been conducted since approvals were granted and intern positions have been fully filled since 1957 through the National Internship Matching Program.

HEALTH PLAN

Kaiser Foundation Health Plan arranges medical, hospital, and related services for its subscribers, primarily in the 12 Kaiser hospitals and outpatient facilities. There are more than 400,000 subscribers in the Bay Area alone.

Treatment is also given to nonmembers, and patients of doctors on the courtesy staff are admitted on a conventional basis, as in any community hospital. The Kaiser Foundation Hospitals conduct a program of charitable care with the assistance of their social service departments, stressing integration of therapy with supplementary facilities in the community. Both the Oakland and San Francisco units are teaching hospitals. In each, staff education is directed by a diplomate of the American Board of Internal Medicine, and both facilities maintain a high level of postdoctoral education activity.

The Kaiser Foundation Annual Symposia are presented for the benefit of the combined staffs of all Kaiser Foundation hospitals and for the medical community, and attract physicians and scientists from this and other countries. Participants have included several Nobel Laureates. The proceedings of the third annual symposium, "The Physiology of Emotions," has been published this year by Charles C. Thomas.

The comprehensiveness of Health Plan coverage and aggregation of material through multiple examinations permit successful clinical studies with follow-up. Substantial funds for research are provided annually by the Kaiser Foundation Hospitals, and facilities are made available to those presenting acceptable plans for such work. The Health Plan population is the subject of numerous epidemiologic projects sponsored by national, state, and other institutions. A department of scientific publication gives assistance in the preparation of medical manuscripts. Abstracts of papers emanating from the staff are collated annually in *Kaiser Foundation Medical Bulletin,* an internationally circulated publication sent on request to physicians and medical students from the publication office in the Oakland hospital.

Oakland

—*Continued from page 83*

Berkeley campus of the University of California with its many research laboratories and a variety of sponsored cultural events. Across the seven-mile Bay Bridge is San Francisco.

Of special interest among the hospital's clinical and research facilities is a radioisotope laboratory where tests for vitamin B_{12} (Co^{57}), red cell survival (Cr^{51}), intestinal protein loss (polyvinyl pyrrolidone), and radioactive fat studies are carried out, as well as blood volume and I^{131} uptake determinations and thyroid scanning. Equipment for special laboratory tests including steroid and other hormone assays is available.

The medical library of 3,600 volumes and 172 journal subscriptions maintains borrowing privileges with area medical schools, state, and county medical libraries. The hospital operates one of the city's emergency services and is the site of the fully accredited Kaiser Foundationing School of Nursing in which residents have opportunity to teach students and instructors.

Residents in pathology may teach in the School of Medical Technology, which is affiliated with San Francisco State College and approved by the American Medical Association. Training in the Oakland Kaiser Foundation Hospital is concentrated at the resident level; the program was established in 1944.

With 94 beds and annual admissions averaging 1,971 patients, the Oakland program in

—*Continued on the following page*

San Francisco

—*Continued from page 83*

The hospital is in one of the most beautiful sections of San Francisco, on a boulevard overlooking city and bay. It is a few minutes' drive from the University of California's medical center, and from the freeway leading to the new Stanford medical center in Palo Alto. Other hospitals, both general and special, are clustered in the same section of the city. San Francisco attracts numerous medical and scientific conventions annually, and with its cultural and recreational facilities, cosmopolitan atmosphere,

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Oakland

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internal medicine is approved for three years, under the direction of Robert C. Goldberg, M.D., Ph.D. Patients are admitted to medical beds by resident staff, and by the 28 internists, many of whom have subspecialty qualifications, and four of whom have Ph.D.'s in the basic sciences.

The resident in medicine serves in rotation through the divisions of cardiology, gastroenterology, and general medicine (metabolic, neurologic, blood, and chest diseases). Individual instruction is given in endoscopy, electrocardiography, and neurology. Residents may follow their outpatients after discharge.

Teaching sessions include daily ward rounds with members of the full-time attending staff, bimonthly departmental conferences with guest consultants from university and other medical centers, basic science lectures, journal club meetings, marrow reviews by the staff hematologist, and several additional weekly conferences and rounds (clinicopathologic conference, tumor board, gastrointestinal conference, neurology conference, general medical and grand rounds).

The approved four-year surgery program has 90 beds available, with more than 2,600 major procedures being performed annually. Under its chief, H. S. Holmboe, M.D., all types of major surgery including thoracic, cardiac, and neurologic, are performed in this hospital. During the graduated program the resident assumes increasing responsibility until, within the fourth year, he becomes responsible, under staff supervision, for patients assigned to him, and follows them after hospital discharge.

Rotation is through the services of urology, orthopedic surgery, plastic, neurologic, and emergency surgery, and the department of pathology.

Didactic sessions include daily teaching rounds and lectures twice weekly by surgeons of the attending staff, weekly sounds by the department chief, surgical pathological and surgical orthopedic conferences, basic science lectures, and monthly journal club meetings. Opportunity is provided for anatomic dissection.

A two-year program in pediatrics, supervised by A. L. King, M.D., records some 70,000 outpatient visits annually in addition to the inpatient admissions to a 40 bed, 50 bassinet wing.

The majority of the 14 full-time attending pediatricians are board certified. Subspecialties include pediatric cardiology, hematology, endocrinology, and adolescent medicine. Residents gain experience in the nonappointment clinic, and follow individually scheduled patients throughout the year. Both inpatient and outpatient services are conducted in the newly erected pediatric wing. Facilities are available for research, especially in metabolic disease, and for special laboratory procedures. An active teaching program includes lectures and demonstrations in the basic sciences, staff conferences for the study of clinical material, daily teaching rounds, weekly rounds by the chief and resident staff, nursery rounds, chart rounds, and a monthly journal club meeting.

Obstetrics

The three year program in obstetrics-gynecology is headed by Robert W. King, M.D., and embraces 50 obstetric and 26 gynecologic beds. With 2600 deliveries and more than 400 major gynecologic procedures annually, the resident receives training in abdominal and vaginal gynecologic and obstetric surgery, radium therapy, culdoscopy, gynecog-

Heart patient on pacemaker is checked by internist on Oakland medical service.

raphy, hysterosalpingography, and other diagnostic studies, treatment of infertility, and pertinent anesthetic techniques.

The department of urology cooperates in instructing the resident in genitourinary procedures.

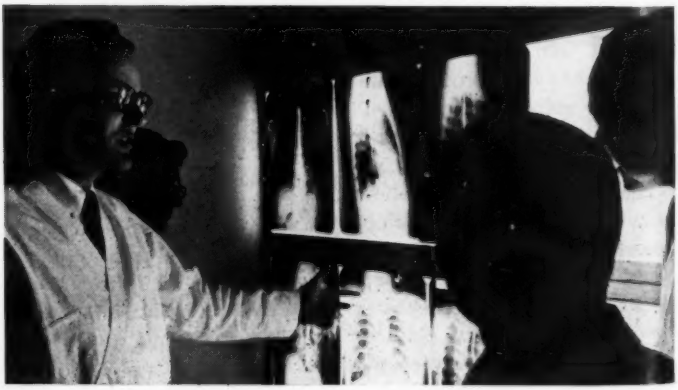
Ample opportunity is given to receive intensive instruction in gross and microscopic gynecological and obstetrical pathology. A large volume of clinical material, classified by electronic sorting machines, is available for statistical analysis and controlled series studies.

The teaching program includes daily ward rounds with a member of the attending staff, weekly general staff and resident conference with discussion led by a member of the attending staff, resident seminar, journal club meeting, monthly meeting led by a resident in the home of a member of the attending staff, morbidity and statistical evaluation meeting, and bi-monthly CPC's. Second year residents attend the weekly conference in obstetrics and gynecology at the University of California Medical Center.

16,589 surgical specimens, performing 508 autopsies (67% of deaths), 430,235 clinical laboratory procedures, and averaging 16,589 surgical specimens each year, the approved four-year program in pathology is directed by Melvin Friedman, M.D.

Residency training in tissue

Films thrown up for viewing and discussion by residents at Oakland.



Spectrophotofluorometry is one of the lab techniques studied by residents.

pathology is open to physicians who contemplate a career in pathology, who wish to study pathology in preparation for another specialty, or who are partially trained in pathology and wish to divide their training program among two or more training centers.

Residency training in clinical pathology is open only to residents who have received or are receiving training in tissue pathology in one of the Kaiser Foundation Hospitals.

The department has a library of 95 volumes, and 10-year files of relevant medical journals, Advice from a senior resident and a staff pathologist are available to the resident at all times, but he is expected to present his proposed solutions as a stimulus to the development of ingenuity and judgment.

Senior residents participate in teaching new pathology residents, surgery and gynecology residents, and medical technology students, and residents in the second and succeeding years are strongly encouraged to undertake research projects of their choice.

The didactic program includes weekly autopsy material demonstrations with case presentations by residents from other services, presentation of autopsy findings by pathology residents, and discussion by the staff pathologist;

regular conferences in surgical pathology with illustrative material from recent cases; slide study sessions in hematology, and semimonthly journal club meetings.

San Francisco

—Continued from page 85

busy international port, invigorating climate, and both natural and architectural charm, the city offers an inviting metropolitan environment to the physician and his family.

The attending staff of this hospital utilizes opportunities afforded for research by the large medical population served. The research program, supported by hospital funds and by grants from outside agencies such as the National Institutes of Health, is concerned not only with studies in clinical medicine, but also with investigation of related basic mechanisms, and with problems in psychosomatic medicine. The research program assists the house officer in keeping abreast of current developments in the various branches of medicine, and encourages his participation in the investigations.

The library, with a certified medical librarian, receives more than 170 periodicals and incorporates new books, editions, and monographs quarterly. It has borrowing privileges from the two university medical centers and state and county medical libraries.

Intern training

The intern serves in rotation in the departments of surgery, medicine, obstetrics and gynecology, pediatrics, and the associated specialties. In addition to clinical and bedside teaching, a formal education program includes seminars, conferences, staff rounds, CPCs, and lectures by visitors. An extensive outpatient department is available for teaching purposes. The intern works five and one-half days weekly and is on call approximately every third or fourth night and every third or fourth weekend. Many interns who receive their training in the Kaiser Foundation Hospital have been selected for vacancies in the resident program.

Surgery

Surgical beds are divided as follows: 54 general surgery, 23 orthopedic surgery, 6 otorhinolaryngology, 4 ophthalmology, 7 urology. There were 4,304 major surgical procedures in 1960. The

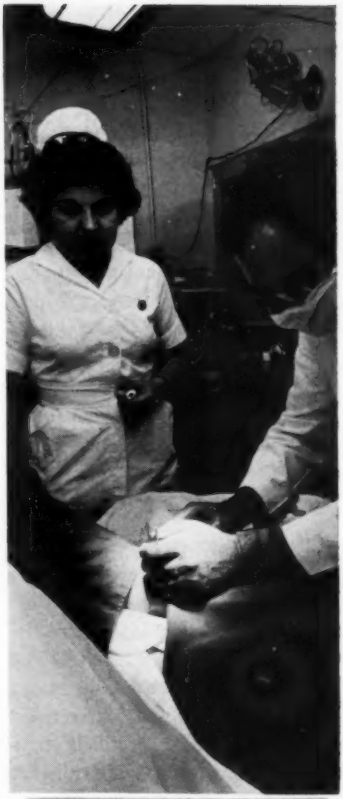
residency program, under P. D. Smith, M.D., is approved for four years.

The full-time attending staff comprises 7 certified or eligible general surgeons, 2 certified orthopedists, 2 ophthalmologists (one certified, one eligible), 2 certified otorhinolaryngologists, and 2 certified urologists. Two physiatrists work in close cooperation with the surgical department.

In resident training, graded responsibility is emphasized. Three of the four years are spent on the general surgical service, with inpatient and outpatient experience in urologic, neurologic, orthopedic, otorhinolaryngologic, and emergency surgery. Six months of the third year are spent in general surgery at the Kaiser Foundation Hospital in Vallejo, north of San Francisco Bay. Six months' training is given in pathology.

There are weekly sessions in radiology, orthopedics, tumor board, surgical grand rounds, and pathology. Guest consultant seminars and journal club meetings are held frequently. Eight residents are trained, two at each year level, graduating two chief residents annually.

The approved, three year program in internal medicine is directed by C. C. Herbert, M.D.,



Including traumatic and medical problems, more than 17,000 patients were seen in emergency facilities last year.

TEACHING STAFF

The teaching-attending staffs of the Oakland and San Francisco Kaiser Hospitals are made up chiefly of members of an independent partnership of doctors, the Permanente Medical Group, with offices in or near the hospitals. They divide among all major specialties, with many representing associated specialties. At least 85% of the full-time attending staff are diplomates of specialty boards or qualified for certification. A number are on the clinical faculties of the two university medical centers in the area (University of California in San Francisco; Stanford in Palo Alto). In house officer training, a stimulus is afforded by these centers, and by other nearby research units.

All house staff training offered is fully approved by the Council on Medical Education and Hospitals of the American Medical Association, and by the appropriate specialty

(inpatient service), and L. E. Harris, M.D., (outpatient service).

Patients are admitted to the 50 medical beds by 22 full-time internists (all of whom are board certified or eligible), 3 certified dermatologists, 3 certified psychiatrists, a certified neurologist, a certified allergist, a certified psychiatrist, and by approved community physicians. There were 1,748 admissions last year.

With emphasis on integration rather than fractionation of care, the resident is responsible under the supervision of the patient's staff physician and the chief of service for the diagnostic and therapeutic treatment of his patients and, when feasible, for related pathologic studies, initial interpretation of electrocardiograms, observation of radiological procedures, presentation at conferences of all material pertaining to his patients, and for their outpatient care under the supervision of various specialists. Teaching rounds and conferences are held weekly. The house staff is of sufficient size to permit time for participation in the scheduled educational activities.

During 1960, 9,482 surgical specimens, 310 autopsies and 345,294 clinical laboratory procedures were performed in the

boards. Applicants for residency must be graduates of approved medical schools, and must have completed an approved internship. A license to practice medicine in the State of California is prerequisite to residency in any hospital in this state, and must be at least in process at the time duties are assumed. Information regarding licensure may be obtained from The Secretary, State Board of Medical Examiners, Sacramento, California. Salaries for residents range from $315 to $570 monthly, with two weeks' paid vacation annually. First year interns receive a stipend and cash allowance for room and meals totaling $240 monthly; married interns receive an additional $25 to $50 monthly. One week's vacation with pay is granted. There are no living quarters in the hospitals, but rooms or homes are available in the neighborhood or within short commuting distance. Medical and hospital care are given to house officers and their families without charge.

pathology department program which is approved for three years under M. L. Bassis, M.D., board certified and full-time chief.

Instruction, principally informal, is based primarily on the study of current material. The didactic program includes demonstrations of interesting autopsy material with case presentations by residents from other services, presentation of autopsy findings by pathology residents and discussion by the staff pathologist, regular conferences in surgical pathology with presentation of illustrative material from recent cases, slide study sessions in hematology, and journal club.

Obstetrics, gynecology

Approximately 135 gynecologic procedures and 250 deliveries are performed each month. There are 39 OB beds and 18 for gynecology, under the direction of H. Bristol Nelson, M.D.

The nine full-time attending obstetrician - gynecologists are board certified or have equivalent qualifications. The attending staff is responsible for the service day and night, and works with the house staff through consultation, supervision, and teaching. Three of the resident's years are spent in obstetrics and gynecology; 6 months, in pathology. Lectures are given weekly on

Individual patient problems and therapeutic management are given thorough consideration in discussions by residents and interns.

obstetrics, gynecology, psychiatry, surgery, pathology, and other aspects of the field.

The chief of service holds a two-hour round table discussion with the residents each Thursday, and makes teaching rounds each morning. Meetings of the journal club, record committee, a statistics conference, and a CPC are held monthly. The obstetrics division is designed and equipped for rooming-in.

Approximate annual figures show 60,000 diagnostic procedures, 5,000 fluoroscopic examinations, 3,000 x-ray therapeutic procedures in the radiology program, which is approved for three years and supervised by H. Nussbaum, M.D.

The five full-time radiologists are board certified. Radiologists participate, by preparing and presenting x-rays, discussing cases and the pertinent films, and discussing diagnosis and treatment, in tumor board, isotope committee, chest, gastroenterology, rheumatic disease, surgery, medicine, pediatrics, and genitourinary conferences. Guest consultant seminars are held monthly.

Annually, more than 700 pediatric admissions and an equal number of pediatric surgical ad-

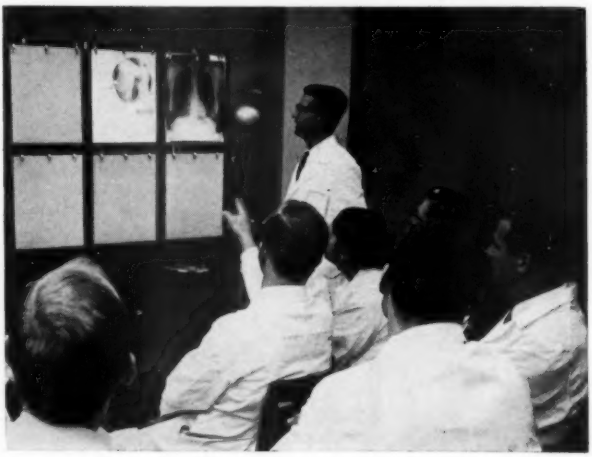
missions, plus 3,000 newborns and some 55,000 outpatient visits are recorded in the 21 bed pediatric service. The two year program is headed by John G. Smillie, M.D.

Eleven full-time staff and two half-time pediatricians (eleven of the total are board certified) cover the service day and night, and are available for consultation and teaching. The pediatric resident participates in the care of pediatric medical and surgical inpatients, newborns (rooming-in offered in the obstetrics department), and pediatric outpatients.

Residents are assigned clinic office hours and responsibilities under attending staff supervision, and accompany staff physicians on home visits to obtain experience with acute infections including communicable diseases. They may see patients in the Teen-age Clinic, under the supervision of the attending staff. Residents see and treat problems of the emotionally disturbed child weekly, with direct consultation and supervision of a staff psychiatrist.

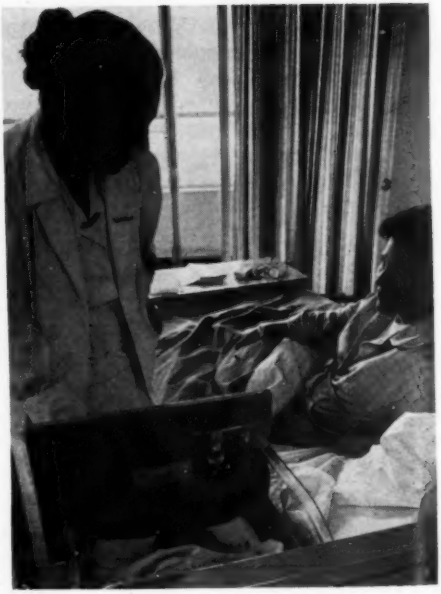
Basic science lectures, given bimonthly by an attending staff physician, emphasize clinical application of the material. The house officer is encouraged to arrange attendance at conferences with the departments of

Regular conferences such as this one on gastrointestinal problems are part of the house staff program.



▲ Full-time librarian serves attending and house staff doctors.

Resident explains rooming-in facilities to new mother in maternity section. ▶



otolaryngology, orthopedics, and allergy. Teaching ward rounds are held daily. Weekly departmental conferences and round table discussions with the chief of service are held.

Allergy

More than 80,000 outpatient visits last year were recorded in allergy. The approved one year program is led by Ben F. Feingold, M.D.

The unusually large volume of clinical material available to the resident in allergy presents him with a broad cross-section of the various clinical problems encountered in the practice of this specialty. There are complete laboratory facilities for training in the preparation of antigens. The department is engaged in an active research program.

Psychiatry

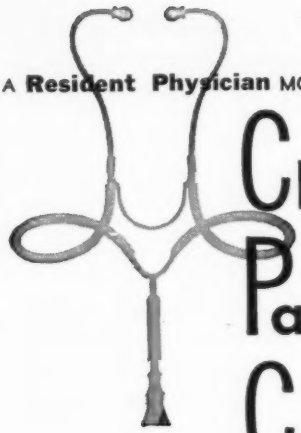
8,517 outpatient visits during 1960.

An approved, 1 year (third year level only) program in psychiatry reported 8,517 outpatient patient visits last year. Under Bernard T. Kahn, M.D., this training facility emphasizes diagnosis and psychotherapy, mainly on an outpatient basis.

The staff comprises three full-time certified psychiatrists (one a diplomate of both the American Board of Psychiatry and Neurology and the American Board of Internal Medicine), two full-time psychologists, one full-time psychiatric social worker, two psychoanalytic consultants, and a full-time board certified neurologist. They and members of the consulting staff individually supervise resident work.

An active research program in psychosomatic medicine and doctor-patient relationships, in affiliation with the Department of Medicine, is maintained under the direction of the Research Committee. The Department of Psychiatry engages in an extensive teaching program for all branches of medicine, including pediatrics in the adolescent clinic, with close clinical supervision provided by a full-time staff. Two years' residency training in psychiatry is a requirement for acceptance as a resident in this department.

A **Resident Physician** MONTHLY FEATURE



Clinical Pathological Conference

Kaiser Foundation Hospitals, California

DR. MARTIN A. SHEARN, *Department of Internal Medicine, Kaiser Foundation Hospitals, Oakland:* A 49-year-old Negro janitor was first seen in the outpatient department of this hospital 3 years and 4 months before his death. He complained of cough, chest pain of pleuritic character, dyspnea, night sweats, wheezing respiration, and nocturia (3 or 4 times nightly). All symptoms were of about one month's duration. Chest film revealed pleural calcification and diffuse increase in markings in both lung fields. The patient was admitted to the hospital.

He had had malaria at the age of 9, gonorrhea at 16, and a chancre at 17. Treatment for syphilis consisted of oral medication, and later, arsphenamine. The patient had had hypertension at the age of 35. Careful inquiry elicited no history of exposure to industrial dusts. There had been no known contact with tuberculosis.

When admitted, the patient appeared acutely ill. His blood pressure was normal, the pulse rate 88 per minute, respiratory rate 32 per minute. Except for a small opacity in the left cornea, and the presence of shotty nodes

in the inguinal regions, the significant findings were restricted to the lung fields, where fine, crackling rales were heard in the posterior and lateral aspects of both lungs. A chest film was interpreted as showing rather extensive fibrotic densities in the posterior thorax with compensatory emphysema and bleb formation.

Roentgen films of the hands showed no abnormalities. The reaction to old tuberculin in a dilution of 1:10,000 was positive. A coccidioidin skin test gave negative results. The sedimentation rate was 28 mm/hr (Westergren). The white blood cell count and differential count were normal; the hemoglobin level was 17 gm/100 cc. The albumin/globulin ratio was normal. The vital capacity was decreased (72%). Persistent search for acid-fast bacilli was unrewarding. The patient was discharged and followed in the clinic.

Three months later he had abdominal pain and hematemesis. A gastrointestinal roentgen series gave evidence suggestive of duodenal ulcer. Therapy appropriate to duodenal ulcer was given, and most of the symptoms ceased. A subsequent gastric analysis showed no free acid.

Nearly 2 years after the patient's discharge from the hospital, a palpable epitrochlear node developed and was biopsied to determine the cause of superficial adenopathy.

Six months afterward, the patient was admitted to the hospital for a second time because of exacerbation of both the respiratory and the gastrointestinal symptoms. In addition, he had dysuria, frequency, and nocturia (4 or 5 times nightly). He now appeared chronically ill. The respiratory rate was 52 per minute. Nontender, freely movable lymph nodes were palpable in the cervical and supraclavicular areas. Some tenderness was elicited over the costovertebral angle.

Laboratory findings were similar to those previously educed. No acid-fast bacilli were found in specimens of sputum and of gastric washings. Spinal fluid contained no evidence of abnormality. The patient was discharged after 17 days, essentially unimproved.

Obstruction

Two months later, he was admitted to the hospital for the treatment of obstruction of the lower urinary tract. Infection with Proteus was proved. On the 36th hospital day transurethral resection was performed. Uro-

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relaxant
potency
for greater
relief
of pain
and spasm

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grams showed no abnormalities. During this hospitalization, the nonprotein nitrogen level ranged from 48 to 80 mg/100 cc.; the creatinine level was 3.7 mg/100 cc.; the calcium level was 10.2 mg/100 cc. An electrocardiogram showed right ventricular hypertrophy. The patient was discharged, improved, on the 44th day.

Three weeks later he entered the hospital because of severe dyspnea at rest, and an increase in epigastric pain with radiation to the anterior portion of the chest and to the throat. The pain was apparently induced by postural changes, and was not related to meals. The appetite remained good.

The respiratory rate was 48; the respirations were labored. Bronchial breathing and egophony were heard over the right scapula; inspiratory wheezes were heard at the base of the right lung and in the left axilla. The fingers were clubbed. The patient improved moderately upon receiving oxygen therapy.

The nonprotein nitrogen level was 45 mg; creatinine 2.3 mg/100 cc; sodium 154 mEq; chlorides 109.2 mEq; carbon dioxide-combining power 22.2 mEq; potassium 5.7 mEq. A second study revealed a sodium level of 134 mEq; nonprotein nitrogen 58 mg/100cc. The specific gravity of the urine was 1.012; the urine contained protein (1+) and white blood cells (20 to 30 per hpf).

[*The electrolyte pattern described was essentially unremarkable except that the sodium level was high initially, and that the carbon dioxide-combining power was within the low normal range, which is somewhat unexpected in a patient with pulmonary emphysema.*]

Therapy

Following therapy with streptomycin, isonicotinic acid hydrazide, penicillin, and cortisone, the vital capacity rose to 46%, 13 days later to 55%, and 5 days thereafter to 67% of normal. For the first time in months, the patient became ambulatory. He was discharged from the hospital.

One month later, slight ankle edema became manifest. The urine contained protein (2+). Roentgen study of the chest showed no change. During the following 3 weeks, a mild episode of prostatitis occurred and responded to treatment. An episode of acute thrombophlebitis in the right leg also responded to therapy. The administration of

cortisone was discontinued because the patient was gaining weight excessively and complained of abdominal discomfort.

He was admitted to the hospital 4 months after the previous dismissal. He now had fever, chills, chest pain, and hemoptysis. In addition to the abnormalities previously observed, a systolic murmur was now heard to the left of the sternum; the albumin/globulin ratio was inverted (globulin, 4.8 gm/100 cc), and an electrocardiogram showed an increase in the degree of right ventricular hypertrophy and the development of a complete heart block.

The patient suddenly became acutely dyspneic and cyanotic. Blood pressure and pulse were unobtainable and he expired.

DR. IRVING I. LOMHOFF, *Department of Roentgenology, Kaiser Foundation Hospital, Oklahoma:* Dr. Shearn and I studied the intravenous urograms and the gastrointestinal studies, before this conference. The findings were not remarkable, except for evidence of a deformed duodenal bulb. In discussing the chest films, I shall make no comment regarding the etiology or differential diagnosis.

Taking as a baseline the date of the first roentgen study, made during the initial period of observation in the outpatient department, the films of the chest may be enumerated as follows: Baseline, 3-month, 13-month, 24-month, 28-month, 37-month, 40-month, and 40 months and 10 days. No lateral views will be shown. They indicated essentially what is denoted here; namely, that the large hilar shadows are due to hilar adenopathy.

Important findings

The important roentgen findings are obliteration of the right costophrenic angle, evidence of calcific plaques in the right pleura, and enlarged hilar densities with a moderate degree of emphysematous and fibrotic change.

The interesting feature of the baseline film is the presence of extremely small nodular densities far out in the periphery, resembling fine dust in appearance. These lesions do not resemble the small, round nodules typical of hematogenous tuberculosis. In addition, emphysema is observed.

The 3-month film shows slight coalescence of the peripheral pattern, and little change in the hilar pattern.

The 24-month roentgenogram shows coalescence of the nodular shadows and an increase in

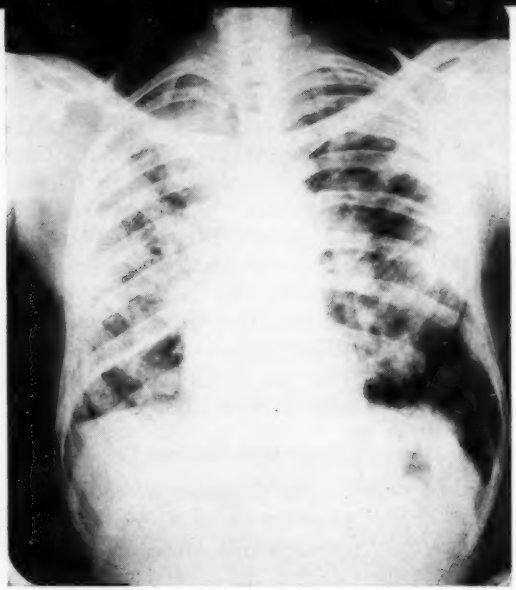

FIGURE 1

the fibrotic strands throughout both lung fields. The hilar adenopathy has not changed. The size of the heart has remained constant (Figure 1).

The evidence of peripheral parenchymal disease has increased on the 28-month film, while the hilar aspect has remained relatively stable. Between the date that this was made and that of the 37-month film, the greatest transverse diameter of the heart increased 2.5 cm; thereafter its size remained relatively stationary.

On the final views, little change is seen in the lung fields.

In summary, the major change in the parenchyma of the lung occurred during the first 2 years of illness, and was followed by relative stability of the roentgen appearance of the lesions. The heart, on the contrary, showed little change during the early course of the disease but increased in size between the 28th and the 37th month. The abnormalities in the hilar region remained without significant change throughout the illness.

DR. SHEARN: Essentially, this middle-aged Negro man had a chronic illness of 3 years' duration characterized predominantly by pulmonary insufficiency which progressed until death. In addi-

tion he had findings referable to the gastrointestinal tract, evidence of renal insufficiency, and diffuse adenopathy. Cor pulmonale and heart block developed, and the patient expired suddenly.

Diffuse pulmonary nodularity of miliary distribution can occur in a myriad of conditions. Many of these, including such acute illnesses as chicken pox, measles, and erythema nodosum, need not enter this discussion. The salient disease requiring differentiation from other possibilities in this instance is pulmonary tuberculosis. The patient had cough, chest pain, hemoptysis, fever, night sweats, and weight loss. Results of an old tuberculin test were positive and in addition, evidence of calcification appeared on roentgen films made early in the course of the final illness. The patient probably did have old, healed pulmonary tuberculosis, which may well have accounted for the positive results of the Mantoux test. In lymphohematogenous or miliary tuberculosis, hilar adenopathy is rare; it is never of significant degree. The roentgen appearance of the lung parenchyma differs from that seen here. The nodules in the lung, since they arise simultaneously, are of similar size and consistency. If this patient had had active tuberculosis, it would have had to be far advanced to cause illness of the degree described; but in far advanced tuberculosis, one can almost invariably demonstrate cavitation. In the host of roentgen films made during the last 3 years of the patient's life, no evidence of cavitation was observed.

Acid-fast bacilli

If the man had had tuberculosis, he would have been much more ill than the protocol indicates, and probably would not have survived 3 years. There would have been high spikes of fever, cachexia, significant loss of weight. Most importantly, acid-fast bacilli would have been found in the specimens of gastric fluid and sputum. Pinner[1] found acid-fast bacilli in 99% of individuals with active pulmonary tuberculosis. Diligent examination will elicit acid-fast bacilli in all patients in whom pulmonary tuberculosis is far advanced and active. Concentrations of acid-fast bacilli in the sputum are high, the Gaffky count characteristically ranging from 6 to 10. At no time were acid-fast bacilli found in this patient.

The diffuse adenopathy typical of pulmonary tuberculosis is characterized by periadenitis.

The nodes are tender; they tend to break down and to ulcerate. In this patient, the nodes consistently remained freely movable, nontender, and were at no time fixed or matted.

Malignant neoplastic disease, especially lymphangiitic metastatic lesions to the lung, often simulates widespread tuberculosis in its roentgen aspects. The densities are prominent in the hilar area, and streak toward the periphery. In this, they differ from the dust-like distribution described by Dr. Lomhoff. A malignant process, in order to present a picture indicating involvement as widespread as this, would have had to be far advanced by the time the patient was first seen.

During the interval between the first hospitalization and death, a primary site should certainly have become evident, possibly in the stomach, since gastrointestinal symptoms occurred. Repeated roentgen studies of the stomach showed no such site.

The patient with malignant neoplastic disease would have been anemic, debilitated, and would have expired sooner than this man did. In an excellent review, Harold[2] analyzed 24 cases of lymphangiitic metastases to the lung. In all instances, once dyspnea commenced, the patients died within weeks or months. The patient discussed this evening had dyspnea when first seen.

Lymphoma group

Hodgkin's disease, and others of the lymphoma group, can cause a picture resembling that described. In Hodgkin's disease, hilar adenopathy is the most evident finding; parenchymal involvement is of lesser degree. Pleural effusions occur in some 75% of cases of Hodgkin's disease; in the final stages, the Pel-Ebstein fever curve and eosinophilia may become evident, although they are infrequently manifest early in its course. In this patient, these phenomena did not occur. The spleen is usually enlarged, and the results of the tuberculin test almost invariably become negative in the late phase. We do not know whether or not the tuberculin test was repeated late in the course of this patient's illness.

Probably the most significant fact related to this aspect of the differential diagnosis is that biopsy of a lymph node was performed, and the patient received no radiation therapy afterward. It is fair to assume that, if the biopsy had given evidence of ma-

lignant neoplastic disease, such treatment would have been administered.

Several mycotic infections can mimic the picture described. Histoplasmosis is one. Pulmonary calcifications are usually found, but their roentgen distribution usually is slightly more uniform than that which we have observed in this patient. In severe cases of histoplasmosis, there is rapid, acute depression of the white blood cell count and of the homoglobin level; the tongue, skin, and nasopharynx are widely involved. The patients do not survive long. In coccidioidomycosis of a degree that could simulate this roentgen appearance, spiking fever, debility, and death may occur within weeks, not years. The results of a coccidiocidin test were negative in this instance.

Any of several diseases due to industrial dusts, including silicosis, asbestosis, and berylliosis, may give rise to such a roentgen pattern; but only rarely do entities of this group develop until after adequate exposure of the patient to dust for periods as long as 5 to 8 years.

Our problem, then, is to identify a disease which can cause the pulmonary picture shown here, can run a chronic course, can involve the lymph nodes, gastrointestinal tract, heart, and kidneys; and which can permit the patient to survive as long as this man did. Boeck's sarcoid is such an entity.

Sarcoid

Sarcoidosis is a chronic granulomatous disease of unknown etiology, with widespread manifestations. Epidemiological studies have indicated that pine pollen may be an important environmental factor, though certainly not the sole one, in the etiology of the disease. Patients with sarcoid are found to manifest abnormal immunological responsiveness although no antibody specific for this disease has yet been found. Familial cases are being reported with increased frequency. It has a peculiar predilection for Negroes. The great majority of the cases reported were in Negroes.[3,4] Although some investigators have derogated from these figures, feeling that they were influenced by certain population factors, corrected figures for patients with Boeck's sarcoid in the United States Army indicate that the Negro appears to have a greater susceptibility to the disease.[5]

The system most commonly involved in Boeck's sarcoid is the lymphatic, which is affected in

approximately 85% of unselected cases. When superficial lymph nodes are so diseased, hilar adenopathy is invariably present; statistically, involvement is most evident on the right, but bilateral hilar adenopathy is also characteristic. The abdominal lymph nodes may be affected and in some instances become extremely large, leading occasionally to pain of such severity that the patient is explored surgically. I suspect that this man's abdominal pain was, to considerable extent, due to enlargement of either the retroperitoneal, periaortic, or other lymph nodes within the abdomen.

The lung is by far the most frequently involved of the internal organs, being affected in 76% of cases of sarcoidosis. More often than in any other entity, the pulmonary abnormalities that can be seen on the roentgen film are resorbed completely, either spontaneously or as a result of corticosteroid therapy.

Several patterns

Various roentgen patterns in the lungs are seen. The earliest, according to Reisner,[3] is similar to that seen in this patient; the distribution is miliary, especially in the lung parenchyma. Alternatively, there may be hilar enlargement with streaking toward the periphery, similar to that seen in lymphoma or possibly in congestive failure. A third typical picture is diffuse, patchy, coalescent areas of fibrotic change. I believe that this patient had several of these patterns of distribution; certainly the miliary and the coalescent areas were present.

Calcification is not seen in patients with Boeck's sarcoid. Pleuritic reactions are frequently observed while pleural effusion seldom occurs. Pleuritic reaction without pleural effusion is well demonstrated in this case.

The symptoms of Boeck's sarcoid are similar to those manifested in this patient; namely, hemoptysis and dyspnea. In addition to the pulmonary insufficiency that ordinarily accompanies emphysema, which results from trapping of air and the irregular distribution of the alveolae, in Boeck's sarcoid the "capillary alveolar block" occurs,[6] apparently because fibrotic thickening of the membrane interferes with diffusion through the capillary alveolar membrane.

Early in the course of Boeck's sarcoid, the patients do well, except that they have dyspnea on exertion or when the need for oxygen is greater than normal. Later in its course, dyspnea is

present even while the patient is at rest, because of the reduced arterial oxygenation that results from the capillary alveolar block.

Since the patient was a Negro, we cannot be certain that he manifested the cyanosis which is the typical sign of the arterial anoxemia; but clubbing of the fingers developed—a characteristic finding in patients who are cyanotic for extended periods.

A vicious chain of events occurs: anoxemia results in the release of erythropoietin and polycythemia ensues, which in turn increases the volume and the viscosity of the blood. These factors, together with the effect of the anoxemia upon the capillary bed and the pulmonary artery, cause increased pressure in the pulmonary artery, which is reflected in the right ventricle. The right ventricle enlarges, hypertrophies; thereafter, the right auricle enlarges and becomes hypertrophied. This leads to cor pulmonale and, by that route, to cardiac failure. Although the roentgen appearance of this patient's heart is not entirely characteristic, it suggests this series of phenomena. Much of the enlargement could have been accounted for by a change in size of the right ventricle.

The electrocardiograms are suggestive. The tracing made early in the clinical course shows right axis deviation, and deep S waves are found in the right precordial leads, as are frequently observed in patients with emphysema. The electrocardiogram made not long before death shows a definite increase in the degree of hypertrophy, with tall peaked (P pulmonale) P waves characteristic of right atrial hypertrophy. Abnormalities are observed on the electrocardiogram of more than 50% of patients with Boeck's sarcoid.

Heart block

Of exceptional interest is the development of heart block. In some patients in whom sarcoid had led to bundle branch block and heart block, postmortem examination has shown the granulomatous lesions or fibrotic change placed strategically along the conducting system. I think it possible that a granuloma situated at or beyond the atrioventricular node, dissociated the atria from the ventricles and caused the arrhythmia, thus constituting the mechanism that was the immediate cause of sudden death. Heart block causes the Morgagni-Adams-Stokes syndrome, comprising cardiac standstill or occasionally ventricular tachycardia. The mode of death

described in the protocol appears to have been compatible with this syndrome.

Interesting speculations relative to the hypotheses that attempt to relate gastric ulcer to the degree of peptic acidity are stimulated by the fact that achlorhydria was observed in this patient, in whom peptic ulcer was suspected. Of a group of 19 patients studied by Scott 4 had gastric ulcers, 4 had pyloric obstruction, 3 had gastric hemorrhage.[7] Achlorhydria was observed in all the patients but one. When examined postmortem, the gastric mucosa was found to be infiltrated with granulomatous material. The hypothesis offered was that the granulomatous sites interfered with the secretion of the parietal cells. Although this patient probably had, separately, a duodenal ulcer which may have been bleeding, it is also conceivable that he was bleeding from some site within the stomach.

Renal changes

The renal manifestations seen in this man, comprising azotemia (functional renal insufficiency without frank uremia) apparently occur in numerous patients with sarcoidosis. The explanation is not always evident. Snapper[8] has proposed that the azotemia is probably due to infiltrations within the arterioles and capillaries, but other investigators have found that the kidneys are usually relatively free from granulomatous lesions. A more likely explanation is that calcium is deposited in and about the renal tubules, or that large calculi develop in the kidneys. Calcifications can be demonstrated in most patients with sarcoidosis and renal insufficiency. The serum calcium level is high in many patients with sarcoidosis. Bone resorption was once suggested as the cause; but the incidence of hypercalcemia is not correlated with resorption.

To suppose that the hypercalcemia is an expression of the characteristic hyperproteinemia of Boeck's sarcoid is not tenable, since calcium is bound to the albumin fraction; whereas the hyperproteinemia of this disease is due to an increase in gamma globulin, or occasionally an increase in beta globulin; and the albumin remains unchanged. It is still not clear whether increased intestinal absorption of calcium contributes to the high calcium level. One report of the calcium level was given in this protocol; the study was made early in the disease; the level might have been found to be higher later in the clinical course.

This patient had two additional

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diseases which might have accounted for the azotemia: known disease of the lower urinary tract, probably pyelonephritis and hypertension, which leads to nephrosclerosis. Both pyelonephritis and nephrosclerosis may depress glomerular filtration rate, and lead to azotemia.

Among the laboratory data, the high sedimentation rate and the reversal of the albumin/globulin ratio are suggestive of Boeck's sarcoid. The elevated hemoglobin level was a result of arterial anoxemia.

Requiring somewhat more explanation is the positive result of the tuberculin test. The etiologic relationship of tuberculosis to sarcoid has been discussed innumerable times, one of the main points at issue being that, in from 60% to 70% of patients with sarcoidosis, the tuberculin test gives negative results. The negative reaction probably does not represent a specific anergy to tuberculin, but rather part of a general defect in the immunologic mechanisms, since patients with Boeck's sarcoid also display anergy to such other antigens as *Candida albicans,* mumps virus, and *Trichophyton gypseum.*

The chronic course of this patient's illness, with an insidious onset, the predominant pulmonary findings, the diffuse adenopathy, the reversed albumin/globulin ratio, and the abnormalities observed roentgenographically, are all highly suggestive of Boeck's sarcoid. The diagnosis of this disease cannot be made definitely except by the observation on histologic section of the typical granulomatous epithelioid areas without caseation.

Final diagnosis

My final diagnosis is generalized sarcoidosis with widespread involvement of the lungs; of the hilar, peripheral, and abdominal lymph nodes; and possibly of the liver and spleen which may be presumed to have been involved since the disease was so widely disseminated. I would expect to find old, calcified, inactive tuberculosis of the pleura, and diffuse sarcoidosis of the lungs. I anticipate that the right atrium and right ventricle were found to be hypertrophied. There may have been infiltration within the heart, and possibly granulomas in the conducting system. The kidney may show chronic pyelonephritis and nephrosclerosis and possibly calcium deposits in and about the renal tubules. I should expect to find an old, healed, duodenal ulcer.

DR. A. J. SENDER, *Department*

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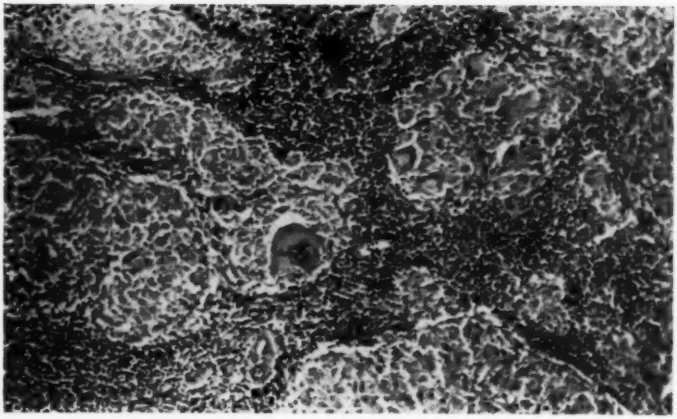

FIGURE 2 Sarcoid granulomata lymph node.

of Internal Medicine: Dr. Raimondi, do you care to comment regarding the administration of cortisone to a patient with a history of duodenal ulcer? Apparently no harm resulted in this instance.

DR. PHILLIP J. RAIMONDI, *Department of Internal Medicine:* In view of the suspected duodenal ulcer, the physician showed considerable courage in using cortisone, which causes an increase in the secretion of pepsin and hydrochloric acid. If the situation requires the administration of this agent, however, it is possible to protect the patient by means of intensive antacid therapy, as was done in this case.

DR. LOMHOFF: It is often said that the patient with Boeck's sarcoid feels surprisingly well in comparison to what one would anticipate from the roentgen appearance of the lung. This patient was ill for a number of years before death. I should like to ask Dr. Shearn whether this would constitute an exception to the rule; or is the concept of the typical "benign" course of the disease misleading?

DR. SHEARN: When the first cases of Boeck's sarcoid were described, roentgen diagnosis was less common than now, and the skin was the most commonly recognized site of manifestation. Those patients in whom the dis-

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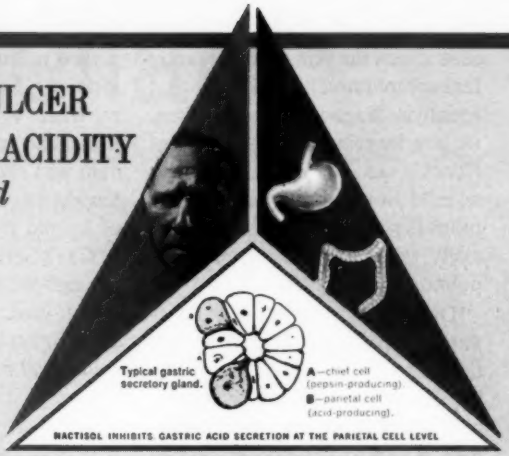

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ease affects the skin predominantly feel comparatively well. Now that roentgen diagnosis is used often, we are learning increasingly that Boeck's sarcoid is not necessarily a mild reversible disease. The mortality rate may be high, especially when there is widespread pulmonary involvement.

DR. MELVIN FRIEDMAN, *Department of Pathology:* The patient had generalized sarcoidosis involving lungs, spleen, liver, kidneys, lymph nodes, testes, thyroid, and probably other organs (Figure 2).

The involvement of the lungs was intensive and extensive. In this organ the disease had reached the late fibrotic stage; most of the tubercles had disappeared, Each lung weighed 1050 gm., about 3 times normal weight. Most areas were firm and rubbery in consistency. The pulmonary fibrosis was of such degree that cor pulmonale resulted. The average thickness of the right ventricle was from 2 to 2½ times normal, and the chamber was dilated. The right upper lobe was occluded by a thrombus, probably originating by embolism from the thrombophlebitic vein in the leg. Milking of the leg veins did not bring out further emboli.

Passive congestion was observed in lungs, liver, spleen, and kidneys. Agonally and terminally, there was esophageal ulceration. The mucosa of the duodenum was slightly scarred and flattened, in a manner suggestive of an old healed ulcer.

Careful block dissections throughout all cardiac areas that might have been involved with the disease failed to reveal sarcoidosis. The prostate was hypertrophied; the aorta, sclerosed.

(Photographs and microphotographs were projected.)

Etiology unknown

Q. What is the present concept of the etiology of sarcoidosis?

DR. SHEARN: The etiology is not known. The hypothesis that related this disease to tuberculosis appears to be losing adherents. Some years ago, patients with sarcoidosis were assigned to tuberculosis wards, where they frequently incurred tuberculosis. Of the 35 patients in the tuberculosis hospital in Denver reported by Reisner, approximately one-third died of rapidly fulminating pulmonary tuberculosis. Now that the disease is being recognized more accurately, and patients are not being exposed to tuberculosis in sanatoria, the frequency of such complications is decreasing.

—Concluded on page 120

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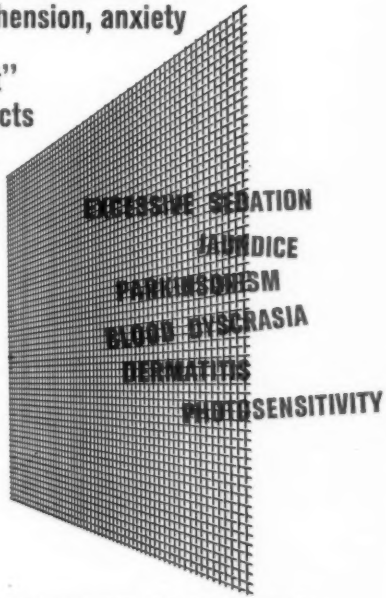

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As I have mentioned, the hypothesis that the disease has an allergic basis is gaining proponents, and the relationship to pine pollen is most intriguing.

Q. Is there a reliable and specific laboratory test for sarcoidosis?

DR. SHEARN: A laboratory test for sarcoidosis, originally devised by Williams and Nickerson and named for Kveim, who in 1941 extended the observations, consists of the intracutaneous injection of an antigen derived from sarcoid lymph nodes. In almost all patients with sarcoidosis, a typical sarcoid nodule, which is histologically identical to those that have been shown, develops in response to such injection. The value of the test is diminished by the fact that a month or more must pass before the lesion develops. The antigen is nonspecific; normal lymph node, normal spleen, and even India ink may elicit an identical response in patients with sarcoidosis.

Pathologist's diagnosis

I. Sarcoidosis of lungs, spleen, liver, kidneys, lymph nodes, testes, and thyroid. Cor pulmonale.

II. Glandular and fibromuscular hyperplasia of prostate.

III. Healed duodenal ulcer.

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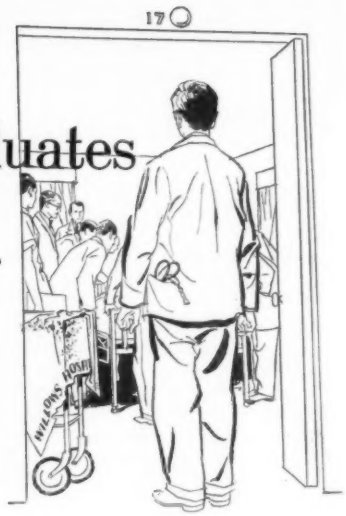
Foreign Medical Graduates in the U.S.A.



The foreign medical graduate represents a challenge to American medicine, one which should be faced honestly.

Marcio V. Pinheiro, M.D.

The presence of foreign medical graduates in American hospitals seems to have created a series of complex problems. Numerous magazine articles on "the problem of the foreign graduates," controversy over the A.M.A.'s Educational Council for Foreign Medical Graduates (ECFMG), bitter complaints from the foreign doctors, themselves, all clearly attest to the existence (and extent) of these problems.

Perhaps more than anything else, the recently formed Association for Foreign Medical Graduates in Boston demonstrates how serious and complex the situation is becoming. It is certainly surprising to find that doctors from other countries, coming to the United States by invitation, choice or need, feel they must form an "Association" to protect their interests.

One need only consider the different (and often opposing) motives and interests of each group involved in the relationship between the foreign physi-

cian and the United States to understand why the problem has become so complex and controversial. Let's analyze these different interests in turn:

● THE UNITED STATES AS REPRESENTED BY THE STATE DEPARTMENT. By creating the Exchange Visitors Program, the United States hopes to advance the medical sciences in underprivileged countries and, at the same time, create a feeling of good will towards the United States among these people.

● THE AMERICAN HOSPITALS. Voluntary, governmental and private hospitals have a present and pressing need for house staff. They are many more times interested in these foreign doctors as "employees" than as participants in a well-developed training program.

● THE AMERICAN MEDICAL ASSOCIATION AND ALLIED GROUPS. The A.M.A. *et al,* in creating the ECFMG, is interested in "protecting" the American patient against the possible hazards of having "poorly educated" doctors in American hospitals. Since it is an association of *American* practicing physicians, the A.M.A. (I would venture to say) seems also to be interested in regulating the number of foreign doctors who wish to come to the United States as immigrants.

● THE AMERICAN UNIVERSITIES. The universities in the United States, mainly interested in teaching and developing the skill of future physicians, apparently hesitate to accept foreign medical graduates: they not only do *not* need them, but they are also naturally afraid of accepting an "unknown foreign doctor" as an intern or a resident not knowing whether he will be able to participate in the teaching program for the university students.

● THE FOREIGN MEDICAL GRADUATE. The foreign physicians are not a homogeneous group but have different interests and motivations even among themselves. The *Exchange Visitor,* for example, will probably be looking for specialized training, while the *Immigrant* and

ABOUT THE AUTHOR

Dr. Pinheiro, a Brazilian physician, has completed one year of rotating internship and two years of residency in internal medicine in private American hospitals. He is presently junior resident at the Psychiatric Institute, University of Maryland, Baltimore, Md.

Editor's Note: *The editor of* RESIDENT PHYSICIAN *considers the views expressed by Dr. Pinheiro to be reasonable and worthy of more than superficial consideration, especially where they relate to those foreign medical graduates who come to this country under the Exchange Visitors Program. Too often in so-called approved hospitals the status of our foreign medical visitor has been that of an underpaid, overworked employee. We feel that those groups who organized the ECFMG should take immediate positive steps to see that an educational program of real value be provided our foreign medical visitors. P.H.L.*

Refugee physicians will be primarily concerned with obtaining a license to practice in the United States.

Reconciling the different views

When approaching a problem as complex as that created by the presence of foreign medical graduate in the United States, all the different motives and interests must be kept in mind. In speaking of the foreign physicians, the category to which they belong must be clearly defined from the very beginning. Conversely, when speaking of the interests of the United States, we must make clear to whom we refer. Is the reference to the interests of the State Department? Or to that of the hospitals? Or the A.M.A. and its allied groups? Or the universities?

Naturally, the ideal situation would be one in which all these different American interests are reconciled and work towards one common goal. However, if (or since) one has to choose or decide which interest is of most importance to the American people, *in view of the present world situation* I believe that the ultimate goal should be that of creating good will for the United States throughout the world. In this case, to reach this main goal some of the "private" interests would have to be sacrificed for the benefit of the nation.

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times that the work of the State Department and the Exchange Visitors Program in creating good will is, consciously or not, directly undermined by the more immediate and particular interests of some American hospitals and, indirectly, by the A.M.A. and its allied groups which approve these hospitals for "training programs." If this is so, these groups should be willing to sacrifice some of their immediate needs so as to be in line with the State Department's plans.

Some needed 'soul searching'

Perhaps the best way to deal with the problems created by the presence of foreign physicians in American hospitals—whether by invitation, choice or need—is to start by answering these basic questions honestly and sincerely:

1. Does the United States *really* think a friendly and honest relationship with these countries is important to its future?

2. Is the United States *really* interested in training these foreign physicians?

3. Does the United States *really* have the facilities to take care of their education?

4. Aren't many private American hospitals making use of the Exchange Visitors Program to further their own personal ends?

5. Does the United States *really* have enough opportunity for an immigrant physician to practice?

6. Is the United States *really* willing to accept "refugee" doctors for what they are and to respect their titles and human dignity?

Three-point program

If these questions can be answered *honestly* in the positive, then a definite plan which would include the following points should be put into effect:

- FOREIGN PHYSICIANS on the Exchange Visitors Program should receive *real* specialized training. This means that all the different American interests would have to subordinate their interests in favor of this one goal. These "visitians," furthermore, should be treated as visitors and receive the hospitality this country is well able to furnish.
- IMMIGRANT PHYSICIANS should be made aware of the obstacles which they will have to face before being accepted in the United States. The U.S.A. has the right to establish any kind of regulations or laws governing their acceptance. However, for the United States to be consistent and avoid well-founded criticism, once the immigrant physician has

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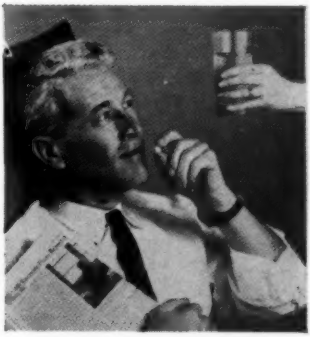
for sustained protection in asthma

One tablet on arising protects through the working day, virtually eliminates the need for emergency daytime medication.



One tablet 12 hours later lets the patient sleep, reduces the need for middle-of-the-night emergency medication.

New Tedral® SA

Sustained-Action antiasthmatic

■ protects against bronchial constriction ■ reduces mucous congestion ■ increases vital capacity and ability to exhale ■ reduces frequency and severity of asthmatic attacks ■ convenient b.i.d. dosage

Each tablet contains 180 mg. theophylline, 48 mg. ephedrine HCl, and 25 mg. phenobarbital.

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GP15

Makers of TEDRAL GELUSIL PROLOID PERITRATE MANDELAMINE

complied with these laws and regulations, he should be accepted with the same rights and obligations as the American-born physician and without racial discrimination.

● REFUGEE PHYSICIANS should be considered as a separate case. Once accepted here—an act clearly illustrating the United States' interest in helping the victims of the communist world—the refugee physician should be helped in securing a comfortable position for himself and his family. Perhaps facilities could be arranged to further their training—if needed—and they should be permitted, once eligible, to acquire a license within their limitations. Otherwise, by using them as "house staff" to fill in the needs of the American hospitals, the altruism and beauty behind the United States' attitude of acceptance and interest will be marred and undermined.

The negative approach

On the other hand, if the questions above were answered in the negative, I would think that, politically, it would really be much better for the United States not to accept any of these doctors. This attitude would be more consistent with the negative answers, and would probably be a happier solution for all the institutions and human beings involved.

Regardless of whose interests are chosen as the most important for the nation, if the United States wishes to be respected and admired by these foreign doctors (and consequently, to a certain extent by their home countries), it must deal with them *honestly, sincerely* and *consistently*.

If the associations, groups, and individuals of the United States do not develop a *real* feeling of interest in these foreign people, if they do not actually believe that such a friendly relationship is pleasant and important to them and the United States, the foreign people will sense this. They will understand that there really is no place for them here and they will return to their homes hostile and resentful of the American people and their institutions. No laws, rules, good will programs, money or even the promise of freedom can substitute for the three pillars on which a long-lasting friendship is based: honesty, sincerity and consistency.

clinically demonstrated – **Sinutab**

provides "excellent symptomatic relief"* of sinus and other common frontal headaches on just 2 tablets q.4h. Sinutab aborts pain—decongests mucosa—relieves pressure—relaxes tension.

*Flohr, Leonard, *et al.*: Clin. Med. 8:3 (March) 1961.

makers of TEDRAL GELUSIL PROLOID PERITRATE MANDELAMINE

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#813

Tax Clinic – *Q and A*

Joseph Arkin, C.P.A.

Q. I want to engage an older physician to scout around the country for a suitable practice for me to buy. I don't want to risk my judgment and feel that one who has been in the field a long time will know what to look for, what questions to ask of the retiring doctor, what to do to assure a fair and equitable financial arrangement. If I employ a doctor on such a trip can I deduct the costs involved—his fee, travel expenses, etc.?

A. You will not be able to deduct the expenses of a "buying agent" since such fees are not "ordinary and necessary" business expenses. They are not incurred in an existing trade or business. Several court decisions have indicated that those who are not business promoters cannot

• *Address your questions to: Editor, Tax Clinic, Resident Physician, 1447 Northern Blvd., Manhasset, Long Island. Personal replies cannot be made, but your question may be answered in future issues of RP.*

deduct for the costs involved in seeking a business. However, when you do purchase a business or practice you generally are permitted to deduct the preliminary expenses involved in its purchase. The latest decision on this is Bernstein TCM 1961-160.

Q. After all the long years of training I think that the high income tax rates amount almost to confiscation of my property. What has happened to the "relief" provisions proposed to help artists, entertainers and professional athletes? Wouldn't this also open the door to giving relief to the professions?

A. While there has been talk of making certain humanizing provisions for certain classes of taxpayers, the present Administration is trying to broaden the tax base by taking away certain special concessions granted to specific classes of taxpayers. Recently a doctor whose return was examined, and disallowances made therein, argued before the Tax Court that the tax laws are "communistic" and therefore unconstitutional. The court held that the taxpayer's contention was unsubstantiated and entirely without merit. He had to pay the tax deficiency. Case of Steck, TCM, 1961-96.

Q. I regularly incur on-the-job expenses which are deductible but which are paid in cash. What records can I keep which will enable me to justify the deductions made for these expenses on my tax returns?

A. The best policy is to pay all deductible expenses by check. This is true whether they are deductible as business expenses or those personal expenses which by special laws are held to be tax deductible (interest, taxes, charity, medical, etc.)

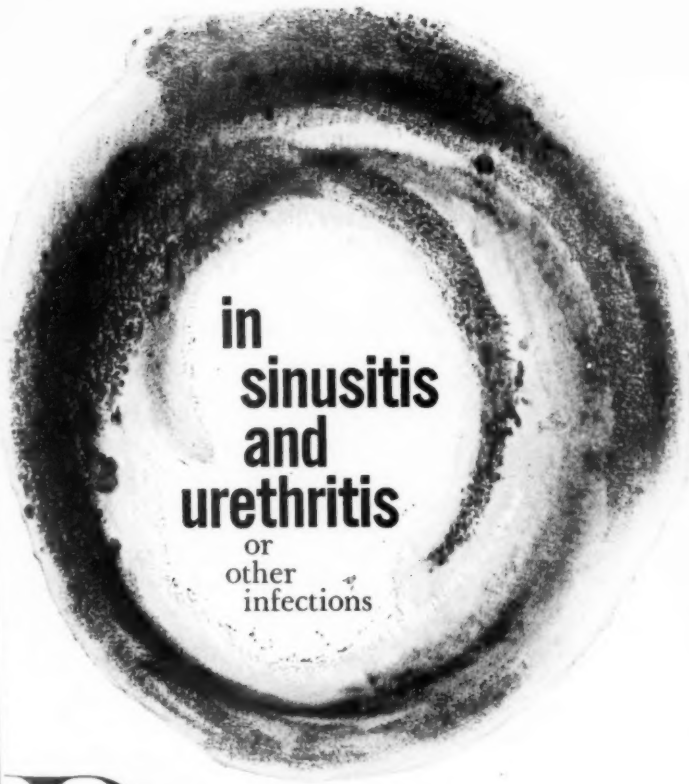
Where you cannot pay by check, because of the smallness of amount, or because of circumstances, the best thing is to obtain a receipt or other evidence of

payment. A good procedure: At the beginning of each year obtain a diary and enter all expenses paid in cash. Will the agent believe you upon examination? Not necessarily, but current practice is to give more weight to deductions claimed when *supported by diary notations,* than by just making estimates of expenses.

In a recent Tax Court case (Weinfeld TCM 1961-17) the court accepted the diary as an adequate form of substantiating expenses, pointing out that the Commissioner, in his own rulings, seems to recognize that travelers and others have to *make cash expenditure* and that these will be considered substantiated if properly recorded.

Q. I have completed all my medical and psychiatric training courses but to be licensed in my state I still have to attend school for additional training in psychoanalysis. I will incur expenses for seminars, lectures, books, and for personal analyses. Can I deduct these on my tax return as educational expenses?

A. No. The Court of Appeals in Namrow (4th, 3/27/61) affirmed a previous decision of the United States Tax Court holding that these expenses were not to "maintain or improve present skills" of the taxpayer-psychiatrist, but rather to acquire a new skill and to satisfy the minimum requirement for establishing himself as specialist in psychoanalysis. The Income Tax Regulations allow educational deductions under certain circumstances, primarily for the purpose of improving one's skill in his employment or business. The court concluded that since recognition as a psychoanalyst can only be obtained by attendance at these special institutes, the taxpayer was in effect, acquiring a new skill. Also, the taxpayer was not allowed to deduct the cost of personal analysis as a medical expense because it was not intended as such.



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against "problem" pathogens— positive broad-spectrum antibiosis

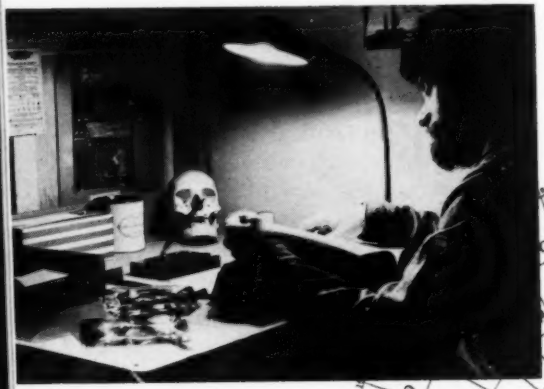
CAPSULES, 150 mg., 75 mg.; PEDIATRIC DROPS, 60 mg./cc.; SYRUP, 75 mg./5 cc.

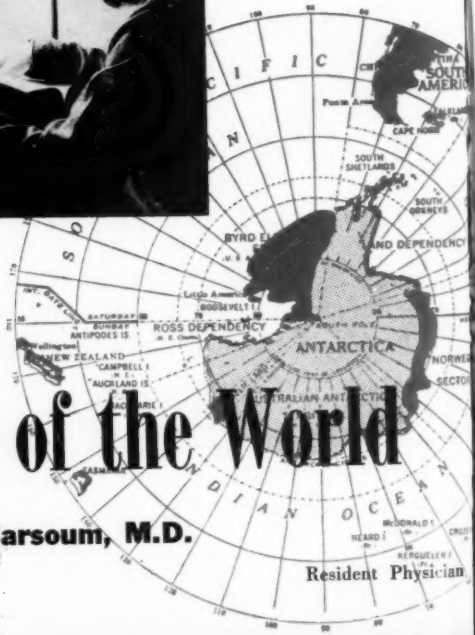
Request complete information on indications, dosage, precautions and contraindications from your Lederle representative or write to Medical Advisory Department.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Medicine at the Bottom of the World

"... The outside temperature was 50 degrees below zero. I sat in my small dispensary under the ice, trying to interest myself in a surgery journal almost one year old. The only sound was the drone of a jet space heater. This had been my home for nine months—and would be for five more months ..."





Adib H. Barsoum, M.D.
Resident Physician

Nearly four years ago, thousands of ice-locked miles from nowhere, a small group of scientists and their assistants chipped away at an enormous mountain of the Unknown. Probably the bits of information they brought back affect us more directly than most of the more spectacular investigations in outer space.

This team had been sent to the Antarctic to study such things as cosmic rays, glaciology, gravity, the ionosphere—in short, man in a special environment. This was part of the United States program for the International Geophysical Year, and I was fortunate to be part of the team.

Orders

I had been a resident in surgery at a large Eastern hospital when I received my orders to active duty with the U. S. Navy. Actually, I was grateful for the opportunity to serve the country of my adoption; I went to the Bureau of Medicine & Surgery, Navy Department, in Washington to request a special assignment—a part in the Navy's operations in the Antarctic during the International Geophysical Year. I knew there was a shortage of physician volunteers and I felt that this would be a rewarding experience that would enrich my life professionally and also spiritually. My expectations were fully realized.

In the fall of 1957, after spending six months at the Seabee training center in Davisville, Rhode Island, carefully screening volunteers, forty of us—ten civilian scientists, five officers, and thirty-five enlisted men — embarked on a Navy transport headed for the Filchner ice-shelf on the Weddell Sea. We were accompanied by a Coast Guard ice-breaker — and a spirit of adventure and the lure of the unknown. Unlike the Ross Sea area, here was a virtually unexplored coastline closely guarded by a treacherous ice pack extending for hundreds of miles out to sea. Forty-five years previously Ernest Shackleton's gallant expedition had met with disaster attempting to negotiate a passage through that same ice.

There were to be six other U.S. stations scattered through-

out the Antarctic, each with one medical officer. Several other nations were also setting up stations on this ice-locked land mass the size of the U.S. and Canada together.

Choosing the team

I had felt some concern over the selection of the men for my station. We were to be the one station out of physical contact with the outside world for a period of thirteen months—and with no possibility of evacuation even in dire emergency. The physical requirements had to be rigorous and surpassed those for the submarine service. Any man with a history of an ailment that might require major surgery was rejected. This included cases of peptic ulcer, cholecystitis, and renal colic, to name just a few.

Prior abdominal surgery, which might make subsequent exploration difficult, also disqualified the candidate. Anyone with any skin disease or peripheral vascular disorder which might make him more susceptible to cold injury was also disqualified. Rare blood groups were carefully paired.

Next, with the help of a team of psychiatrists, we delved into the mental processes of our candidates. A high motivation was considered the prime requisite. Individuals volunteering to escape personal problems were turned down. There was to be no extra financial remuneration so this never complicated the picture. Candidates were selected from seasoned, experienced, rated Navy men.

ABOUT THE AUTHOR

During the years 1957 and 1958, now called the International Geophysical Year, over fifty nations undertook a concentrated and unprecedented study of man's physical environment. Part of this intensive investigation took place at Ellsworth Station, Lat: 77° 42.9' S Long: 41° 07.6' W, the United States base in the Antarctic. Here the author, for a space of 13 unforgettable months, "practiced medicine." Dr. Adib H. Barsoum, born in Cairo, Egypt, is a graduate of the School of Medicine, University of Alexandria, Egypt. He immigrated to the United States in 1955 and interned at the Mercy Hospital (Chicago). He is currently Resident in Surgery at MacNeal Memorial Hospital (Berwyn, Illinois).

Breaking the ice. Coast Guard Ice Breaker Westwind clears the way for the United States IGP team.

Setting up shop

Early in January 1958 we moored alongside the ice-shelf. Ellsworth Station, our home for the coming year, was situated a mile from the coast. It consisted of a small group of buried huts built over floating ice 800 feet thick which like a giant glacier tongue was still attached to the polar ice-cap. Seven-eighths of the shelf was submerged. Penguins waddled up to supervise unloading operations with a critical eye, while seals basked in the never-setting summer sun. Killer whales lurked unseen beneath the thin sea ice, ready to pounce on any hapless men or beast who ventured on it. The weather was a balmy 28 degrees.

The two ships had to offload and get out to sea quickly since the pack was closing in and

threatened to trap them. One ship had already suffered heavy punishment going through the ice pack.

Medical unit

The station medical unit consisted of a treatment room, a one bedroom sickroom, a storage room, and the medical officer's quarters. This was in the building occupied by the officer-in-charge and the chief scientist. I had a modern field x-ray unit, a dental unit, a laboratory unit, and a large amount of medical and surgical supplies. I was assigned a chief corpsman who was not only an operating room technician but a laboratory and x-ray technician to boot. He turned out to be a regular Jack-of-all-trades, a true Antarctic man.

Since many items could not withstand extreme low temperatures, it was necessary to store them in the building and an emergency generator was kept there to guard against central power failure and the loss of valuable drugs. A substitute station was erected close to the main one and a duplicate dispensary was set up there. This was a necessary precaution in case the main station was destroyed by fire. A French station the previous year had been destroyed in this manner and the whole party had to be evacuated. Had this occurred in winter they would all have perished from the cold.

The problem of a fresh water supply and sanitation was easily resolved. Fresh water was obtained by melting snow. Mechanical shovels poured clean snow down chutes into heated tanks and the water thus formed passed through a series of filters into large storage tanks within the buildings. Sewage was disposed of in large trenches under the buildings. It froze solid immediately and created no further problems.

Antarctica practice

One of the main problems we faced during the summer months was insomnia. Many couldn't sleep because of the constant daylight. Men would remain awake for 48-hour stretches without any desire to turn in. Only meal periods kept us aware of the passage of time. Eventually the men overcame this "big eye," some with the help of mild soporifics.

Another complaint was a dry hacking cough and frequent sore throat which was caused by the low absolute humidity of the cold air with the subsequent drop in relative humidity when the air

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Buried but busy. The smoke stacks of the buildings are the only clue to the activity going on under the ice at Ellsworth Station. In the background is the radar dome used to track down weather balloons.

was heated in the buildings. This problem became worse during the winter months when air at temperatures as low as minus 70 degrees below zero was heated to +68 F inside the buildings. Humidifiers partly remedied the problem, but there were always those who had difficulty sleeping because of the dryness. We all suffered from an inordinate thirst.

The incidence of frostbite was negligible for we were all equipped with scientifically insulated clothing. A few first degree cases occurred on exposed faces but those healed with little treatment.

A mild case of snowblindness was seen in a glaciologist who had to do surveying work with his glasses off. There was no residual retinal damage.

Injuries consisted of minor lacerations, a rib fracture from skiing, and a herniated lumbar disc treated successfully with bed rest and traction. Even when a 35-ton tractor fell into a 75 foot deep crevasse the driver and his companion miraculously escaped with only minor injuries.

If winter's here . . . Clean, crisp medical dispensary. Over the bed, a glimpse of spring pictured on wall of Medical Officer's quarters.

A civilian scientist came down with an attack of malaria which he had contracted in the tropics the previous year. He was kept on a prophylactic course of anti-malarial drugs for the remainder of his stay. It seems odd now—malaria in Antarctica.

Another man came down with ulcerative colitis. Proctoscopy confirmed the diagnosis and steroids controlled the condition.

My greatest worry was a case of ilio-femoral thrombophlebitis in one of our senior scientists. Fortunately, adequate amounts of anticoagulants were available or it would have probably terminated fatally.

One of the most aggravating problems that came to plague me was the loss of dental fillings. When cold air was inhaled through the mouth, it contracted and thus loosened the amalgam. I replaced most of them as best I could and filled in new cavities but in a couple of instances I was forced to extract badly carious molars. Luckily—or rather,

thanks to someone's foresight and good planning—a two-week course in dental emergencies taken prior to leaving the States partially prepared me for this unexpected development.

Fatalities

I was spared the tragic aircraft accidents, the fatal falls in crevasses, or through the sea ice that had occurred at other stations.

In two instances, I prepared for the worst: once, when one of our light ski planes was lost with two men aboard. We found them a week later on the escarpment a hundred miles away having run out of gas after getting lost in a blizzard. They had survived the minus 30 F temperature thanks to good survival training and they were none the worse for their experience. The second scare came when we received an order by radio to search for a lost Belgian team in a vast unexplored area lying between us and a Belgian station a thousand miles away. We were laying out fuel depots to extend the range of our light aircraft when fortunately the team was located by overland search parties from their own station.

As winter approached, we had day after day of magnificent sunsets, unequalled and nearly indescribable in their breathtaking beauty. The ice was suffused with delicate pastel shades and the wind created a weird lunar landscape out of the shifting snow. Above all the absolute silence which descended at intervals on the vast landscape created such a sense of unreality that the modern civilized world seemed remote and detached.

The long winter night finally arrived; it was to last four months. Between the week-long blizzards there were intervals when the winds died down, the stars appeared, and we were treated to displays of aurora australis (southern lights) in startling colors. There were shimmering draperies, flaming bands, radiating coronas, and multicolored arcs; all intermingling, vibrating, expanding and contracting before our eyes.

But winter also brought its problems, not all of them medical. Besides being medical officer I was assigned certain additional duties which included writing the weekly press releases, acting as communications officer for a brief period, and finally as recreation officer. The latter task was one of combatting the demoralizing effects of boredom and ennui during the long dark

On the beach. Actually, a traverse party from Ellsworth Station sets up temporary camp, another outpost in the expanse of ice and snow.

winter months. Parties were organized on every occasion and on no occasion. There was a well stocked library, a large collection of records, hobby materials to please every taste, pool table, shuffle board, table tennis, dart boards, a couple of electric pianos, a gym and a fresh movie for every day of the year.

In spite of varied recreational facilities, the psyche reared its head. Sick calls increased to a record high during the early part of the winter. Complaints ranged from headache and insomnia to gastrointestinal troubles and vague aches and pains. Most of this was a somatization of repressed feelings. Before long each man had begun to realize the significance of living at close quarters with 39 other men of different personalities and temperaments. They began to learn to accentuate their virtues and minimize their faults and idiosyncrasies in the interest of harmony

Take an "inside look" at a remarkable advance in topical steroid therapy

Veriderm Medrol consists of Veriderm, a base closely approximating the composition of normal skin lipids, and Medrol, highly effective corticoid.

Topical use of Veriderm Medrol Acetate produces symptomatic relief and objective improvement of dermatoses, and at the same time aids in correcting dry skin conditions. Veriderm Medrol Acetate, less greasy than an ointment, less drying than a lotion, is indicated in atopic, contact, or seborrheic dermatitis; neurodermatitis; anogenital pruritus; allergic dermatoses.

Available in four formulations: Veriderm Medrol Acetate 0.25% — Each gram contains: Medrol (methylprednisolone) Acetate 2.5 mg.; Methylparaben 4 mg.; Butyl-p-hydroxybenzoate 3 mg.; in a skin lipid base composed of saturated and unsaturated free fatty acids; triglycerol and other esters of fatty acids; saturated and unsaturated hydrocarbons; free cholesterol; high molecular-weight alcohol; with water and aromatics. (Veriderm Medrol Acetate 1% is also available.)

For prophylaxis against secondary infection: Veriderm Neo-Medrol Acetate 0.25% — Each gram contains: Medrol (methylprednisolone) Acetate 2.5 mg.; Neomycin Sulfate 5 mg. (equivalent to 3.5 mg. neomycin base); Methylparaben 4 mg.; Butyl-p-hydroxybenzoate 3 mg.; in a skin lipid base composed of saturated and unsaturated free fatty acids; triglycerol and other esters of fatty acids; saturated and unsaturated hydrocarbons; free cholesterol; high-molecular-weight alcohol; with water and aromatics. (Veriderm Neo-Medrol Acetate 1% is also available.)

Administration: After careful cleansing of the affected skin to minimize the possibility of introducing infection, a small amount of either Veriderm Medrol Acetate or Neo-Medrol Acetate is applied and rubbed gently into the involved areas. Application should be made initially one to three times daily. Once control is achieved — usually within a few hours — the frequency of application should be reduced to the minimum necessary to avoid relapses. The 1% preparation is recommended for beginning treatment and the 0.25% preparation for maintenance therapy.

Contraindications: Local application of Veriderm Medrol Acetate or Neo-Medrol Acetate is contraindicated in tuberculosis of the skin and in other cutaneous infections for which an effective antibiotic or chemotherapeutic agent is not available for simultaneous application.

These preparations are usually well tolerated. However, if signs of irritation or sensitivity should develop, application should be discontinued. If bacterial infection should develop during the course of therapy, appropriate local or systemic antibiotic therapy should be instituted.

Supplied in 5 Gm. and 20 Gm. tubes.

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and for their own emotional well being.

By the end of the winter sick calls had become so rare that the medical officer found himself whiling away the time by hooking up volunteers to thermocouples and conducting experiments on their tolerance to cold, the efficacy of the different types of cold weather clothing and the blood cellular changes during exposure.

. . . And daybreak

Summer brought a feverish renewal of activity. Trail parties fanned out into the trackless ice mass. New mountain ranges were discovered. New areas were explored and mapped, and a wealth of valuable scientific data was accumulated.

First aid kits had to be prepared and personnel indoctrinated in their use. I learned not to send aqueous solutions in glass bottles because they inevitably froze, expanded and broke the bottles. Rubberized materials became brittle and cracked or splintered in the cold. The colloidal properties of plasma substitutes became irreversibly altered by freezing. I had to foresee the possibility of an accident several hundred miles away with no chance of quick evacuation to the station due to weather conditions.

These and many other problems kept me absorbed so that when an ice-breaker finally showed up in February 1959 to take us home, I felt I had spent an active, memorable and exciting year.

With the arrival of the ship, an epidemic of common colds broke out among our groups who had not been exposed to outside infection for over a year. In spite of that, when we finally arrived home in April (after being locked in the pack for a month) we looked healthier, happier, and more relaxed than when we left. Several of the men have since volunteered for another tour on the ice. I am still fighting the impulse.

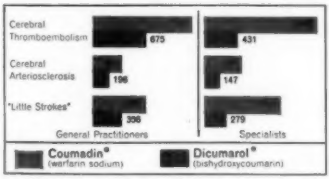
No. 3 of a series reporting on Endo Laboratories' Anticoagulant Survey

Nationwide Survey Explores Current Use of Anticoagulants in Cerebrovascular Disease

It has been estimated that there are 2,000,000 people suffering from vascular disease of the brain in the United States,[1] and that each year at least 500,000 persons are incapacitated by some kind of cerebral accident.[2] With the advancing age of our population, this problem is likely to increase.

As reported in previous numbers of this series, Endo Laboratories received replies to its comprehensive *Anticoagulant Survey* from a total of 10,016 physicians across the nation. Among the questions asked were—Are you now using oral anticoagulants for cerebral thromboembolism, cerebral arteriosclerosis, or "little strokes"—therapeutically, prophylactically? Without regard to the anticoagulant chosen, 14.4% of physicians reported use of oral anticoagulation in *therapy* of cerebral arteriosclerosis, 27.9% in little strokes, and 46.9% in cerebral thromboembolism. Anticoagulation was used *prophylactically* as follows: 10% in cerebral arteriosclerosis, 16.8% in little strokes, and 21.2% in cerebral thromboembolism.

Comparison of usage was also made among the 61.4% of reporting physicians prescribing Coumadin® most often and the 27.6% using Dicumarol®. (The remainder used indandiones [1.9%] and other anticoagulants.) The following graph shows the application of the leading anticoagulants *therapeutically* in cerebrovascular disease:

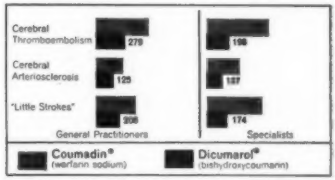


Physicians Using Oral Anticoagulation Therapeutically in Cerebrovascular Disease

Specialists Lead in Therapeutic Application of Anticoagulants

The analysis of the data presented in this survey indicates that 57% of the cardiologists and internists prescribing Coumadin—the most frequently prescribed oral anticoagulant—and 42% of the general practitioners used the drug therapeutically in cerebral thromboembolic disease. It is also noteworthy that 39% of the specialists used Coumadin in therapy of "little strokes" as compared with 22% of the general practitioners. Less frequent was its use as part of the therapy of cerebral arteriosclerosis—18% among the specialists and 12% among the general practitioners.

Anticoagulation was used less often for prophylaxis than for therapy of cerebral thromboembolism, little strokes, or cerebral arteriosclerosis, as shown in the following graph:



Physicians Using Oral Anticoagulation Prophylactically in Cerebrovascular Disease

Indications According to Recent Clinical Reports

It is generally agreed that anticoagulants help to minimize the occurrence of attacks in patients with *transient ischemic episodes*,[3-6] which are "far more common than was previously suspected."[3] In addition, anticoagulation is advocated in the slowly evolving *stroke*,[5-7] i.e., "slow-onset" infarction. The value of long-term anticoagulation in *cerebral embolism* appears well established.[3] Similarly, in *completed cerebral infarction*, such treatment can minimize recurrences and reduce the mortality rate.[8] The findings of Thomes suggest that "there is no time when it becomes safe to discontinue anticoagulant therapy."[8]

1. Meyer, J. S.: Am. J. Med. 30:577, 1961. 2. Kuhn, R. A.: Current M. Digest 28:51, 1961. 3. Groch, S. N., and Wright, I. S.: Circulation 23:458, 1961. 4. Siekert, R. G.; Millikan, C. H., and Whisnant, J. P.: J.A.M.A. 176:19, 1961. 5. Carter, A. B.: Neurology 11:601, 1961. 6. Marshall, J.: Ibid. 11:139, 1961. 7. Groch, S. N.: Ibid., p. 141. 8. Thomes, A. B.: Minnesota Med. 42:1587, 1959.

3-Man Partnership Practice that Failed

What started out as a dream plan for three young MDs gradually became a nightmare. Combining their private practices, they soon discovered that office overhead, new equipment, staff expenses and the inequity in the amount of income each brought into the partnership had caused a serious change in their relationship with each other. In less than a year, the partnership started to crack.

This personal account of the split-up of a three-man partnership, which began in RESIDENT PHYSICIAN *last month, is concluded in this issue.*

The first hint of a break-up came when we began to get a "corporate vision" of our practice. We all began to think of our offices and staff as a unit which should be able to produce income. The trouble was, only one of the partners did anything about it. He began to drive, in his own practice, for a high volume of tests, lab exams, x-rays, etc. This wasn't the way we'd started out to practice.

So now there was a basic conflict in professional attitudes, one which had not been evident when we first formed our partnership.

The income inequity, due to Bob's drive, became greater—and the greater it became, the more Bob's demands increased for time off, entertainment benefits and other advantages—none of which had been spelled out in our contract.

We made compromises. In each case, Joe was the one who suffered since he was "low producer" among the three of us. He slipped into the status of a junior partner, contrary to our plans at the beginning. Thus the whole idea of a joint and equal partnership practice had started to evaporate.

We were tense now. Not easy and informal with

each other. Finally it got to the point where each of us resented the others seeing our patients. This was because of —of all things—our bookkeeping setup.

Our books showed pretty much what each man was contributing to the office. If it showed that one was only contributing so much one month, the others might come up with "Look, you didn't do it last month, therefore you should work an extra two nights." Once it got to that point, it was just ridiculous.

Patients

As might be expected, we had the usual complaints from patients who said we were making ourselves unavailable, that we were becoming big shots and they didn't like this arrangement and they felt that the patient-doctor relationship was the most important thing in the practice of medicine and we were destroying it. When they called at night, they didn't want Dr. So and So, they wanted *you.*

Trying to explain that no doctor can work 24 hours a day didn't have any effect. When they called and didn't get you, they felt that you were deliberately trying to avoid being found. And these same complaints came to each of the three of us.

Yet, most of our patients apparently thought it was a good idea when we first decided on a partnership. The reception to it was good. We of course had brought out all the good points to those who were interested. I had told my patients that there would always be someone on call; when I was on vacation they would have a man who knew their case and had access to their complete record—not the usual type of coverage.

I also stressed the availability of consultation: "Here you will have not one brain but three." We had felt that it would be nice to sit around and go over our interesting cases together, drawing on the best cases for discussion. That's one of the real advantages of partnership in a profession.

Of course, we knew when we started into this that there were certain patients who would never be satisfied not to be seen by their *own* doctor. Many patients form a very strong personal relationship, and in their mind you are the only man who can take care of them. We felt however, that some could be convinced and won over to the partnership arrangement once they realized how effective it was.

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1. Cornely, D.A., and Ritter, J. A.: N-acetyl-p-aminophenol (Tylenol Elixir) as a Pediatric Antipyretic-Analgesic. J. A. M. A. *160*:1219-1221 (April 7) 1956.
2. Mintz, A.A.: Management of the Febrile Child. J. Ky. Acad. Gen. Prac. *5*:26-31 (January) 1959.

Deciding not to worry and take our chances, we found we lost some and won some. But after the bookkeeping setup became the strong factor, that is, how much income each of us "produced," this sharing of patients was abandoned.

Expenses

Coloring all our actions was the basic problem of meeting tremendous expenses. We had a really heavy weekly payroll. And we were shocked when the bank sent us our quarterly notice of insurance plus Social Security which was due. Also, there was workmen's compensation, sickness and disability, liability and so forth. This plus a tremendous increase in our overhead. Everything did not triple as you would expect when three combined into one, but quadrupled and quintupled.

Our drug bills became very high, whether we used up more or what I don't know. Costs of x-rays were high and phone bills were running $400 a month. But it was pretty obvious that we weren't making much money, even with a wonderful set-up and with greatly increased growth in practice. As a matter of fact we were making a good deal less in net income than we had as individuals—and it was a very tight situation.

Taxes

But we understood that once we got our bills paid and our debts began to ease that our net would gradually pick up. And we agreed to hold out. But the point was obvious as time went on, that we were working hard, and making on paper at least, a lot of money, but we were not doing that well. We were just paying our debts and many months we scraped.

Of course, we were hit with a tremendous income tax by virtue of the fact that we were paying taxes on money which we never saw—which was another point not apparent before.

We had to pay taxes on nearly all this money we were paying for equipment. When you think about it, it's obvious, but it was not obvious to us when we went into this. We never saw any of this money; it came into the office and immediately went to the bank to pay our loans. Yet this was all taxable income. So tax period rolled around and in addition to paying living expenses, I had to borrow money and Joe had to borrow money to pay taxes. This added to the tension between the three of us.

The financial problem was a great one, there's no question about it. Very great. Perhaps we should have understood that this was going to happen.

Then, the inequities that I mentioned before relating to income coming into the office became much more important; Bob's demands became magnified—became important. And the little things, which we had always agreed we would have no trouble in handling, became problems. The remarks, backbiting around the office and pushing for extra advantages by each of us, rapidly moved our situation to the point where it was only a question of time as to how long our partnership would last.

Vacation

At about this time, my turn came for a vacation. When I got back, my desk was loaded with messages to call so and so, and so and so, etc.

I don't know why, but it so happened that everyone I spoke to did nothing but complain. They didn't like the man who was covering for me, or the man said he was "too busy and couldn't come" to see them; there was one complaint after another, and quite frankly at this point I just exploded.

Of course, what had happened was the mutual coverage, which was supposed to be such a wonderful advantage of partnership, had gone down the drain. Bob felt that he was busy enough and that he was not going to see my patients, and he saw no reason for seeing my patients. And Joe, who should have been seeing them, at this point was being so hounded by Bob primarily, and I suppose by me, too, that he started to get slightly paranoid about the whole thing, resenting the fact that everything was being sloughed off on him. Yet, when we would get together, the argument was there that "look I'm doing more and bringing more money into this office therefore I want more time off and I figure that I should have greater benefits" and, "Joe you are doing less and you should be doing this covering and also be building your own practice." The fallacy, of course, was that Joe could never build a practice because *we weren't letting him do it.* So it was perfectly clear to Joe that

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1. Woodruff, C. W., "Iron": Borden's Review of Nutrition Research, 20:61, 1959.

Filmtab—Film-sealed tablets, Abbott; U.S. Pat. No. 2,881,085.
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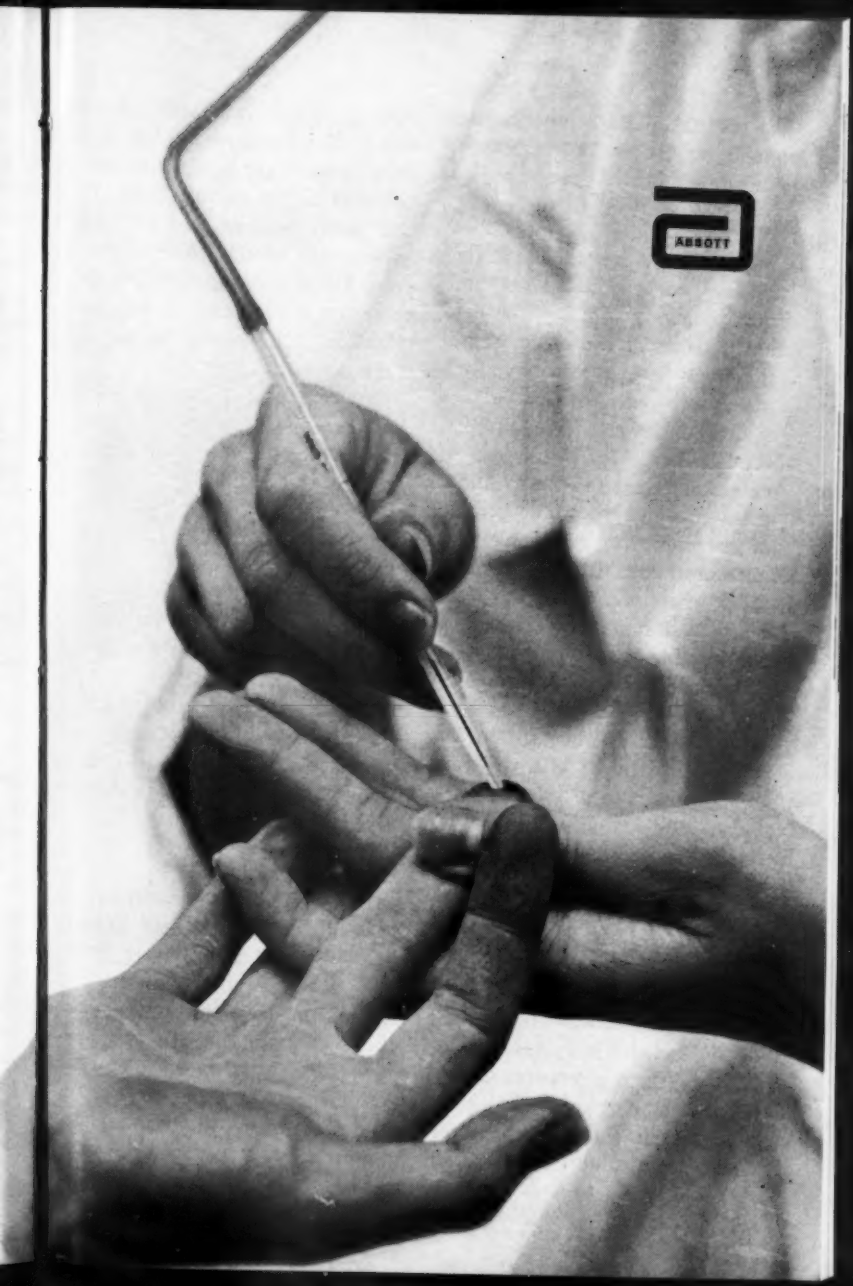
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he couldn't build a practice, nor could he satisfy Bob as far as money-making was concerned.

Pressure

After vacation, when I started getting complaints, I became quite unhappy with just the general tension of the office, something that had never bothered me in solo practice. I had had a very relaxed office; my nurse who had been with me for years was no longer as relaxed, she was under pressure—and the whole general office setup was becoming very uncomfortable. It is a horrible thing when you walk into your office and don't feel right and comfortable.

I felt that either we were going to make this thing work and try to get back on some sort of an equitable basis or else we were going to have to dissolve it.

Bob and I discussed the situation by ourselves first. He felt that Joe had a personality problem and that the patients didn't like him. He saw no hope for it and felt that Joe was riding a gravy train and wasn't contributing his fair share. This in spite of the fact that Joe was working nights. You see, you can charge around making night calls but this doesn't show much in income. And unfortunately, with Bob everything was reduced to dollars and cents; everything that went down in the books was dollars and cents, nothing else. It was pretty obvious that we had had enough of this. And at this point I was no longer willing to compromise in any way, we might as well arrange to break it up.

We next had a meeting with Joe and discussed it with him. He was the one who was actually hurt by this because he was left in a heck of a predicament. His practice hadn't developed at all. And though he felt he didn't want the partnership to break up, he had had enough of the backbiting that went on and was tired of being a stepchild.

So we agreed to hang on until the partnership, now seven months old, had run for a year. Then we would dissolve it. Actually, we didn't last it out.

Inferior medicine

Perhaps you're wondering if each of us might not have looked upon the others as having been bad doctors, practicing an inferior brand of medicine—and that this was an underlying problem. This wasn't so. Sure, we had a personality problem. Bob wanted to make a million dollars —and he may very well do it on

his own. But I'm not criticizing at all his medical practice. Bob wanted complete tests, x-rays, b l o o d s, BMR's, EKG's, the works. Yet, none of these things can be criticized in the sense that certainly you may see a patient who has some blood in the stool and you sigmoidoscope him and you find internal hemorrhoids which are bleeding. Now it becomes a matter of opinion whether you go ahead with a barium enema.

Whereas I might say the source of bleeding here is obvious and there is nothing that would indicate the need for a barium enema, someone else could say that to be absolutely thorough, a barium enema was needed. These are points in my judgment that are very tenuous. True it is very easy to make another $35. But you have to be pretty unusual to call this poor medicine. Because it is more profitable, it is not bad medicine.

So as to the type of medicine that we practiced, we were individuals, well trained and exercising individual judgment.

Only a few weeks more had passed before we finally agreed on what the next step would be. We would end the partnership agreement by mutual consent. But, since we still had the lease on the offices we agreed it would be best to go along on a shared facilities basis, for a while at least.

This new arrangement meant that our income would be maintained separately by each of us. Our bills would be divided according to our use of materials and facilities, and we would keep a receptionist and a technologist, as well as one nurse. On x-rays, costs would be prorated according to the work each man did and drugs and other supplies were to be ordered and inventoried separately by each of us.

Patients

We notified our patients that we were maintaining individual practices. Actually, most making any comment on this change—and few commented—appeared happy with the new plan. In their eyes each doctor was now available full time for his own practice. And since we are available, of course we don't get the time off we did under the partnership.

Since we hadn't gotten together with our families on a social basis too much, there never was any problem as far as our wives were concerned. They of course know each other—but the relationship has never been so close that they joined forces

on our practice problems and influenced any decision.

They are just as friendly with each other as before. Somehow, women seem to live through these things with far less involvement than men. Of course, they really didn't *get* involved—and that was a good thing.

Now what will happen? Will we go on like this? Well, some changes will occur. More staff, probably. But it is possible we'll move out one by one, too. I just don't know.

Postmortems

Postmortems are never fun. And when you're the cadaver, it's unpleasant. But since the object of my telling this is to help you who may consider a partnership one day, this CPC may help.

Looking back, each would-be partner should clearly express his interest—financial, social, professional, philosophical. That's most important. If there is an obvious conflict in goals, call it off.

I felt we would sacrifice for the first three years, perhaps end up with a 10 per cent increase in net income—but more important, have more time off, plus consultation. But, as it developed, these ideas were not shared by my partners.

Secondly, we overshot ourselves. Financially we were in over our heads right from the start. We counted on x-ray income, but it didn't develop.

So I would say, don't overload yourself with equipment that will put you in debt. Get the best setup *eventually,* but don't try doing it all at once, because you will be terribly shocked at the expense—and taxes.

This, of course, pertains to the financial relationship of the partnership, out of which can grow many ills, and which is very important.

Personality

But still, the basic problem, let's face it, is personality. You can sit down with a guy and at the time see no possible source of conflict. But as things start to work out, bang! There it is. And how some of these partnerships go along, resolving conflicts, I don't know. There might be three people who are of exactly the same temperament, and who just happen by fortuitous circumstance to get together, and there's no problem they can't settle because they all feel the same about it. But it would be luck, it seems to me.

We studied this thing from top to bottom; we weren't going to make any mistakes. We analyzed

everything except the financial aspects. That's the place where we didn't have a detailed plan. Taxes, income, salaries, schedules, rates, equipment purchases, all the way down the line as an accountant would run it—this undoubtedly would have helped. And this was a surprise, no question about it. We were impulsive, and that certainly was a mistake we made, not getting a detailed analysis.

Yet, you see, we could have overcome that, because after all, the gross potential was there, providing payments were adequate. Incidentally, I didn't mention this but fee payments were slow coming in, much slower than in solo practice. Maybe patients had a corporate view of our setup, too. This may have hurt our chances.

Again?

Would the advantages that were potentially inherent in a partnership cause me to consider doing this again within a year or two? I ask this question because I was probably the most enthusiastic of the three of us about partnership practice. Now this break-up hurts—don't think it doesn't. So I'm sure I will certainly be wary because of this experience.

I think the best arrangement a physician can make when he gets to the point where he's relatively busy and wants some help, is to find a young fellow in the area to come in—at first just to cover weekends. There is always someone new coming into the area who wants such an opportunity—and needs it.

As for a mixed group, I don't think I would be interested. If a fellow starts off in a group, it's fine. But if he's used to being on his own, as I am, I think the adjustment would be pretty rough.

Mistakes

Probably what I have said will have very little effect on someone else, a resident or intern who has his dream setup just beginning to form in his mind. I suppose you are always convinced that you can evaluate; that's what you are saying to yourself.

Well, we knew what we wanted, we were all adults, we weren't going to make any mistakes.

But we did.

And I hope you will be able to profit by them.

URGENT TASKS CONFRONTING MEDICINE

Continued from page 75

committed to the career earlier, in some cases, in high school, certainly by freshman year in college, and, if faculties of arts and sciences and of medicine could get together effectively, a blended course of general and professional education could be offered which would permit graduation in medicine in six, or seven, years after matriculation at the freshman level. Such shortening could be accomplished by pruning the medical curriculum of non-essentials, eliminating duplication between the arts and sciences program and the medical program, and by better integration and correlation throughout; integration vertically, as well as horizontally. I believe that such a combined program would attract more students, not alone by saving them both time and money, but hopefully by making more sense than the present fragmented affair, and by providing more meaningful goals and more powerful stimuli.

Another suggestion for increasing recruitment of medical students is to entice more women into medicine. Some countries, notably Russia, have a very much higher percentage of women in medicine than do we. From my own experience in this matter, which goes back at least to the middle twenties when we began taking women interns on the Medical Services of the Massachusetts General Hospital, I have formed the opinion that women are as capable of becoming fine physicians as are men, and that we should welcome as many well qualified ones as we can get. It should be pointed out, however, that women who raise families may not be able to give enough time to medicine to justify the costly education which they have received. This presents a dilemma, which I will not attempt to resolve. The fact that President Kennedy has chosen a woman to be his personal physician should be a strong fillip to

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the recruitment of women for medicine.

New curricula

Also bearing on the problem of making medical education more appealing, and at the same time, more efficient, is a proposal by David D. Rutstein,[11] Professor of Preventive Medicine at Harvard, which has become interestingly controversial. "The medical schools," says Rutstein, "since the Flexner Report (1910) have pursued a policy which favors the education of experts, i.e., scientists and specialists, rather than general physicians." This is all right, we need such people, the very best obtainable, but we also need well trained general physicians in far greater numbers, and our medical schools are falling behind in producing them. "A possible way out of this impasse," Rutstein believes, "is to follow the lead of schools of technology, such as M.I.T. They have recognized that the educational needs of the physicist and the engineer are different. Although students entering these fields may start off together, their curricula diverge." This is not to say that one is inferior to the other. "In medicine," Rutstein continues, "a similar program is possible. Two curricula can be designed—one for research workers, specialists, and the other for general physicians." I must confess to seeing considerable virtue in Rutstein's proposal, but Dana W. Atchley,[12] of Columbia, fears that it would lead to a segregation of sheep from goats, so to speak, and that Gresham's Law would soon apply. He prefers that we only aim at producing sheep, and would sooner see part of the community get on without medical services than be cared for by the goat-type of doctor. If his premise is correct, I would have no disagreement with him, but I do not believe that it follows that Rutstein's two-curricula proposal would inevitably lead to a sheep and goat product. I think the product could all be of sheep, but of two different kinds of sheep. All students could be given the best possible education for what they are going to do, but what they are going to do will fall into categories with different educational requirements.

First rate care

This much will have to do on the problem of increasing the supply of doctors. Let us now approach the problem of how can their services be used most efficiently, economically, and expediently. What is the best way to

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bring first rate and up-to-date medical care to all of our people —best that is to say for the people? To any detached viewer it will be at once obvious that solo practice, fee-for-service, free choice of physician, is not the answer—at least in our present culture.

Under such a system, and with doctors getting in even shorter supply and therefore enjoying a sellers' market, fees may be expected to rise in accordance with the economic law of supply and demand. If medical care were a commodity which, if forced to do so, we could safely go without, then the market mechanism would be a satisfactory method of distributing it. But medical care is not a commodity; it is, as stated before, a professional service, the benefits of which are needed by all, and to which according to our prevailing social and ethical philosophy all people are entitled, whether they can pay its costs or not. The situation is comparable to that of public school education.

Costs

Medical care, of course, includes many more services than those of physicians and surgeons; the costs of hospitalization, for instance, nursing, social service, and other paramedical services, the cost of drugs, many of them probably unnecessary, and a variety of appliances. All of these costs are skyrocketing in an alarming way. What portion cannot be paid for by the patient has to be paid by government supported or voluntary agencies of one sort or another.

Availability

Not only does the increasing relative scarcity of doctors make professional services more expensive, but it makes it progressively harder for patients to obtain them. It is harder than it used to be to see a doctor, or to get him to see you. This does not necessarily signify any flaw in his professional conscience; it may be merely an indication that he is overworked. There can be no doubt that many practicing doctors, because of their inadequate numbers and their antiquated methods of practice *are* overworked. And if overworked, they become fatigued, like anybody else, and if fatigued, the quality of their work *can* decline.

Poor geographic distribution of doctors presents another problem —there are probably not too many anywhere, but the scarcity is greater in some areas than in others. Planning to provide better distribution, both of total number

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*Youngblood, V.H.; Tomlin, E.M., and Williams, J.O.: Gynaecologia (Supp.) *149*:76 (Part 3) 1960.

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of doctors in any locality, and also of the ratio of generalists to specialists, is on the whole, but in its infancy.

Planning for the location of hospitals so that in any wide area their facilities may be available to both patients and doctors alike, in relation to actual need, is also very important.

Organization for medical care, therefore, would seem to be in order. In a national health service like Britain's, organization for medical care is of the essence. Far too much so, doubtless would be the comment of many American doctors. But we may ask, can we do something of the sort by voluntary effort? At least we can try.

To date it would seem that the most promising approach in the United States is through some form of voluntary group practice. Some progress has been made in this direction already. At the meeting of the APhA at San Francisco last November, the results of a nationwide survey of group practice in the United States by the NIH was presented by Dr. S. D. Promrince, director of the survey.[13] Some significant points emerged. For example, between 1946 and 1959, there had been a threefold increase in the number of practice groups. At the present time there are about 200,000 MDs in the United States and over 10,000, or five percent of the whole, are practicing in groups. It is a *growing movement.* The growth is faster in some parts of the country than in others. When the number of doctors in full-time group practice is related to that of solo practicing physicians, the highest concentration of group physicians, 18 percent of the total, is found in the block of seven North Central states, and the lowest in the states along the Eastern seaboard from Maine to Florida—the conservative East!

Report

To quote the Pomrince Report, "The predominant activity of medical groups is the provision of general medical care (as distinguished from referral work or diagnostic only.)" The groups have both generalists and specialists among their number. Patients have one of the generalists as their personal physician, and the specialists in the group are chosen to represent those specialties most commonly needed. Such groups have their own clinic or office facilities, and they must have access to proper hospitals where they can continue in charge of hospitalized patients.

H.I.P.

Perhaps the most distinguished adventure in group practice is the Health Insurance Plan of Greater New York, which is a *chain* of practice groups scattered throughout all its boroughs. It has over half a million subscribers and is steadily growing. There can be no question that it gives high grade medical care and that there is general satisfaction among both its patients and doctors. Several medical societies have tried to scuttle it, but thus far have been unsuccessful.

Much criticism has been directed at medical practice groups, chiefly by conservative doctors, to the effect that the personal relation of doctor and patient is lost. It can easily be shown that this is not so, and it can be pointed out in favor of groups that in present day society they offer the only dependable 24-hour, 365-day-a-year coverage. Some groups still work on fee-for-service, but the fees are collected by the administrative office, put in a kitty from which the doctors are paid salaries agreed to by the group itself. Other groups have achieved prepayment, meaning that their subscribing patients pay an annual fixed premium, and together with Blue Cross or its equivalent, get budgetable prepaid comprehensive medical care.

Doctors of the present generation are apt to be strongly opposed to working on salary, but I would like to point out that doctors working full time for universities or governments are paid by salary, also doctors serving full time in the practice groups which are on prepayment. Many other professionals, teachers, college presidents, clergy, and others are paid by salary. Why not doctors? Doctors should be well paid because they have invested much in their education and have acquired considerable skill, but if they really love medicine and are in it for its own sake, they can be happy on salary. In all probability, as practice groups increase, and solo practice dwindles, the great majority of doctors will be on salary. This will be one of the adjustments that will be required of the medical profession by the type of world we face.

Research

There are a great many variations of the group practice principle, and these as they function are on trial before the people. One can even say that the whole movement is a great experiment of the sort which I believe the


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medical profession is morally obligated to make. It must be willing to do research, and make explorations in the educational, administrative, social, and economic areas of medicine, no less than in the biologic.

Special fields

In the biologic areas, as a matter of fact, research is doing very well. That is why, important as it is, I haven't had more to say about it in this particular lecture. It is at the moment in happier case than either practice or teaching. There has been since World War II an incredible expansion in funds for the support of research, both from governmental and private sources. The chief problem becomes that of finding people who show special promise of being able to do original and creative research. When found they should be supported generously and given great freedom to follow their lines of inquiry as their own scientific imagination directs. They must, of course, at any time have access to enlightened criticism.

There are many special and new fields of medicine which urgently need to be advanced, such as occupational, industrial, environmental, rehabiliative, and social medicine, but unfortunately, there is not time to discuss these now. Instead, in closing I will mention but one, namely the psychiatric.

The provision of psychiatric care at the present time is singularly inadequate from the community point of view. There are, in the first place, not nearly enough psychiatrists, and those that we do have are sometimes too doctrinaire to be useful on a community-wide basis. The psychoanalytical technique, undoubtedly a powerful instrument for exploring the human mind, is too costly in both time and money to have application to more than a handful of highly selected patients. More expeditious methods of supplying our huge number of neurotic persons with psychotherapy will have to be made available, and for our appalling number of major psychotics, something better than locking them up in mental hospitals will have to be developed.

There are thus plenty of urgent new tasks for you to sink your teeth in. I wish you all success in undertaking them.

I thank you.

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Osler Said This . . .

BOOKS ARE NOT ENOUGH

The very marrow and fatness of books may not suffice to save a man from becoming a poor, mean-spirited devil, without a spark of fine professional feeling and without a thought above the sordid issues of the day . . .

To study the phenomena of disease without books is to sail an uncharted sea, while to study books without patients is not to go to sea at all . . .

In what may be called the natural method of teaching the student begins with the patient and ends his studies with the patient, using books and lectures as tools, as means to an end.

WILLIAM OSLER, M.D., 1849-1919.

QUIET, PLEASE!

YOUR WIFE'S TALKING

Lynn H. Mandelbaum

A Special Marriage

"Ours is going to be a special kind of marriage," my physician husband warned when he proposed. I wasn't sure what he meant then, but believe me, I am now.

I am not a nurse (unlike the author, RESIDENT PHYSICIAN, September 1960, "A Difficult but Rewarding Role"). I don't subscribe to the extreme point of view that a doctor's wife must completely subjugate herself to her husband and forget that she is an individual with thoughts and feelings. However, like the author of "Too Much Hogwash?" (RESIDENT PHYSICIAN, May 1961), I was a resident physician's wife for a few years. I have recently graduated to the position of wife of a practicing physician. The "Hogwash" author has yet to experience this "unique" position, and perhaps when she does, she will forget her "me, myself and I" attitude and consider the purpose of her role in its entirety.

Is marriage to a doctor like "any other marriage," as the resident's wife claims? I never thought so, and do not now. Even as a medical student's wife, there are extra sacrifices and responsibilities one must

assume above and beyond the duties of the average young married. Terms such as "interdependence" and "interrelationship" are wonderful, and I am all for them. They are definitely essential to any good marriage.

But, what does a doctor's wife do when the vacation trip has been planned and the luggage must be reactivated from the tops of closets, and packed — and hubby is nowhere to be found? Probably he is at the office, but more likely he is cheering up his heart patient at the hospital. We'd sure love a little of that "interdependency" here, but we swallow hard and get the ladder.

Human being

What does a doctor's wife do when the big evening out to a hospital affair comes along, and the little wife is hysterically happy, thinking that at last she will have her man to herself? But does she? Of course not! The doctor gets involved with the others discussing an unusual case at the hospital, while his wife circulates among the wives with a stiff upper lip, wishing for a little more "interrelationship."

I believe, however, that a good doctor's wife, not just "any wife of any husband," as the previous author puts it, will make a special effort to smile and accept it.

Yes, the doctor is a human being, as the previous author suggests, but he is also quite special. There are many times he would like to sleep through the night without an emergency call but can't; his bones are ach-

Throughout my husband's internship . . . and the recent completion of his residency . . . I have avidly read the magazines you mailed to him. Of particular interest to me, have been the articles entitled "Your Wife's Talking." Here, I feel, is finally the opportunity for the distaff side to make her views known. Perhaps some of it might be considered "hogwash," inhuman or even a little self-righteous. But, after all, each of us is entitled to her own opinions, and I sincerely hope that you will give mine a chance to be published. They are in reply to an article subtitled, "Too Much Hogwash?" in the May 1961 issue.

The extreme remarks made in this article, so stirred my feelings, that I felt I must write down what I consider to be a more faithful picture of a doctor's wife and her role in society.

L. H. M.

ing and his muscles cry out for rest, but out of the house he goes —three in the morning. Of course he would have loved to have seen that new Broadway musical for which you both had tickets for weeks, but a last minute call disrupts all plans and ends a beautiful dream.

If the doctor is a little special, it follows so must be his wife and thus his marriage. No good husband, doctor or not, wants his wife kneeling at his feet waiting for the next command. This type is not a "bigger than thou" physician, as the above author states, but simply a "bigger than thou" person.

Efficiency

♡Marriage is not meant to be an efficiently run job, where a wife's personality is thwarted or nonexistent, and here I do agree with the resident's wife. However, she overlooks this fact that on the contrary, a wife's and particularly a doctor's wife's responsibility, is to enrich her personality and broaden her horizons in order to help her marriage and her husband in his profession.

Now this is where I differ and take issue with the previous author. Marriage is not just two people "adjusting and relocating" for mutual satisfaction. That is almost equivalent to saying that "man is an island entire of himself," unless he happens to find an amiable companion!! Marriage should be a stable relationship wherein two people reach out to others around them for friendship, love, help and even mutual benefit.

Share, support

♡Yes, a doctor can love his wife and family and still feel a prime responsibility to his patients. This is something a doctor's wife must share. *This* is the kind of support our physician husbands want. They know they have our love, or why would we have married them in the first place and had their children? (Any doubters in this department should seek help.)

In her attempt to elevate the position of wife and mother, the above author has discredited it. She does her best to prove the worth of woman's place in a good marriage, but in doing so, only renders woman more worthless. Ours, yours and mine, is a special marriage, one in which a wife can reap even greater love and happiness if she is willing to give a little of herself to her husband's "other love," — human lives.

♡ ♡ ♡

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162 mg.	Acetophenetidin	162 mg.
227 mg.	A.S.A.®	227 mg.
32.4 mg.	Caffeine	32.4 mg.

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What's the Doctor's Name?

The first to teach general anatomy from the descriptive, histologic and comparative angles, he was a dramatic and popular teacher at the University of Edinburgh as well as an interesting writer on anatomic illustration and natural history. His "The Races of Man" (1850) is an original and very readable contribution to anthropology, one praised by Ralph Waldo Emerson.

But he is best known from his association with the terrible "Burking" crimes. These were the times when bodies for dissection were secured by secret and devious means. Graves were

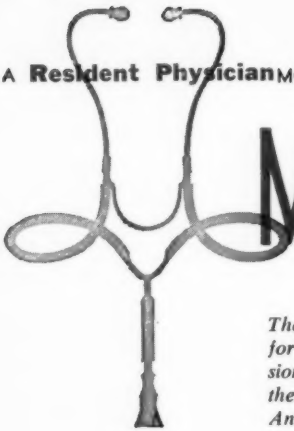
robbed and funeral hearses waylaid by Resurrectionists and "Sack-em-up" men. In the case of a certain William Hare, murder was the means. Owed four pounds by a lodger who had died, Hare sold the body to the doctor at a profit. With his associate Burke, the two then entered upon a career of murder, intoxicating their lodgers and suffocating them by closing their hands tightly over nose and mouth ("Burking"), then selling the bodies to doctors for a profit. Their victims numbered sixteen, the last of whom, before they were caught, was found in our doctor's rooms.

All Edinburgh was aroused, particularly since two of the dead were women. The doctor was excoriated by press and pulpit, and mobs threatened to hang him.

The doctor, innocent of prior knowledge of the crimes, faced his attackers bravely and defended himself in writing, but his career was over.

As an aftermath, Lord Warburton's Anatomy Act of 1832 provided that unclaimed bodies go to medical schools. Can you identify this doctor? *(Answer on page 197.)*

A **Resident Physician** MONTHLY FEATURE



Mediquiz®

These questions were prepared especially for RESIDENT PHYSICIAN *by the Professional Examination Service, a division of the American Public Health Association. Answers will be found on page 193.*

1. Keratitis sicca occurs most often in:

A) States of dehydration.

B) People who work in the open air, such as farmers.

C) Infants with congenital absence of the lacrimal ducts.

D) Aged, arteriosclerotic males.

E) Women around the climacteric.

2. The stage in the course of a brucella infection when the patient is most apt to develop eye involvement is:

A) During the first week after subsidence of the acute symptoms.

B) Within 24 hours after the onset of acute symptoms.

C) Shortly before the onset of systemic symptoms.

D) The chronic stage.

E) During the most acute stage of the disease.

3. Moebius' sign often seen in the post-encephalitic Parkinsonian syndrome is the inability of the eyes to converge properly. It is also seen frequently in:

A) Cerebellar tumors.

B) Injury to the cervical sympathetic nerve chain.

C) Thyrotoxicosis.

D) Carotid-jugular fistulae in the neck.

E) Lead poisoning.

4. A 50-year-old woman complained of a swollen right eye of

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sudden onset. Examination revealed edema of the lids, conjunctivae and cornea on the right with moderate exophthalmos and ophthalmoplegia. The orbital contents were observed to pulsate and a murmur was audible over the temporal region. The cause of her difficulty was probably:

A) Retro-orbital angioma.

B) Retro-orbital hemorrhage.

C) A carotid-cavernous sinus aneurysm.

D) Retinal detachment.

E) Thrombosis of the central retinal vein.

5. A Colles' fracture is characterized by the so-called 'silver fork' deformity of the wrist. This is brought about by the:

A) Avulsion of the ulnar styloid.

B) Perilunar dislocation of the carpus.

C) Dorsal angulation of the articular surfaces of the radius.

D) Palmar angulation of the articular surface of the radius.

E) Proximal displacement of the radial styloid.

6. Volkmann's contracture is considered to be caused by:

A) Direct injury to the muscles.

B) Injury to the nerve supply of the muscles.

C) Interference with the blood supply of the muscles.

D) Congenital deformity of the muscles.

E) Calcification of the muscles.

7. The proper treatment of the Bennett type of fracture of the first metacarpal bone requires:

A) Adduction and fixation to the hand.

B) Immobilization in extension.

C) Immobilization on a straight dorsal splint.

D) Immobilization on a curved splint.

E) Abduction and traction.

8. The best method now available to increase the number of cures of cancer of the stomach is to:

A) Perform total gastrectomies.

B) Decrease the incidence of pulmonary embolism by vein ligation.

C) Irradiate the abdomen after gastrectomy.

D) Reduce the delay from onset of symptoms to surgical intervention.

E) Advocate the wider use of nitrogen mustard.

9. Which of the following questions would be most effective in testing a provisional diagnosis of irritable colon in a patient complaining of abdominal pain?

A) Is your abdomen usually tender?

B) Do you tend to bloat after meals?

C) Have you had any black stools?

D) Do you tend to vomit a great deal?

E) Are your pains relieved by belching?

10. The treatment of choice of congenital spherocytic hemolytic anemia is:

A) Vitamin B_{12}.

B) Liver extract.

C) Iron.

D) Spray irradiation.

E) Splenectomy.

11. A 2-year-old boy was examined because of frequent pro-

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tracted nose bleeds. Laboratory data revealed a mild hypochromic anemia, normal white cell count and differential, platelet count 310,000 (venous blood, method of Tocantins), prothrombin time 14.5 seconds with 14.0 seconds control (quick method), bleeding time (Duke) 2.0 minutes, clotting time (Lee and White) 47 minutes, clot retraction time 40 minutes, tourniquet test (cuff pressure midway between systolic and diastolic pressure for 8 minutes) showing 5 hemorrhagic spots in a circle 5 cm. in diameter. Among the following the most likely diagnosis is:

A) Purpura hemorrhagica.

B) Constitutional afibrinogenemia.

C) No disease except blood-loss anemia.

D) Hemophilia.

E) Allergic purpura.

12. The most common cause of chronic secondary hyperparathyroidism is:

A) Chronic renal disease.

B) Diabetes mellitus.

C) Tumors of the parathyroid gland.

D) Hyperthyroidism.

E) Tumors of the anterior pituitary gland.

Answers and References
See Page 193

Leads and Needs

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Answers and References

(From page 180)

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5(C) Item writer's experience: approved by 3 reviewers.

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12(A) Williams, R., Textbook of Endocrinology, 610.

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X-RAY DIAGNOSIS

(Answer from page 22)

COOLEY'S ANEMIA

Marked widening of the medullary cavities of the skull (including the facial bones) and of the distal portions of both upper extremities. The widening has produced thinning of the cortices. There are numerous small calcific areas in the medullary cavities as result of infarcts.

EKG DIAGNOSIS

(Answer from page 28)

COMPLETE RIGHT BUNDLE BRANCH BLOCK

The tracing illustrates the typical findings of complete right bundle branch block. The presence of RBBB does not necessarily indicate myocardial disease, in contrast to LBBB.

WHAT'S THE DOCTOR'S NAME

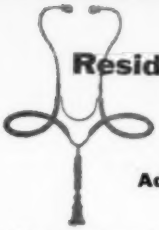
(Answer from page 178)

ROBERT KNOX

DERMATOLOGICAL DIAGNOSIS

(Answer from page 36)

Allergic contact dermatitis due to ragweed oleoresin.



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